

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12392

12407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 2				d. STREET ADDRESS Westminster, Md. R. D. 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Calvin M. Albers				4. DATE OF DEATH Month Day Year 11/13/59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/28/1894	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ezra Albers				14. MOTHER'S MAIDEN NAME Rosa Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-2862		17. INFORMANT Address Mrs. Calvin M. Albers, Westminster, Md. R.D.2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis (c) Valvular Heart Disease				INTERVAL BETWEEN ONSET AND DEATH sudden 1 month 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 15, 1959 , to Nov 13, 1959 , that I last saw the deceased alive on Nov 13, 1959 , and that death occurred at 10:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Julius Chepko				M.D. 85 1/2 W Green Westminster Md DATE SIGNED 11/13/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORY Grave Run Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

1901

County		City	
Madison		Madison	
Name of Deceased		Age	
John, W. Anderson		40 Years	
Residence		Occupation	
Anderson, W. A. D. 2		Anderson, W. A. D. 2	
Date of Death		Time of Death	
April 12, 1901		10:30 A.M.	
Cause of Death		Place of Death	
Diphtheria		Home	
Influenza		Hospital	
Typhoid		Sanatorium	
Tuberculosis		Nursing Home	
Scarlet Fever		Asylum	
Smallpox		Quarantine	
Measles		School	
Whooping Cough		Church	
Dysentery		Cemetery	
Typhus		Prison	
Malaria		Farm	
Epidemic		City	
Other		Other	
Signature of Physician		Signature of Registrar	
J. W. Anderson		J. W. Anderson	
Date of Report		Date of Report	
April 15, 1901		April 15, 1901	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12393	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12408	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville					c. LENGTH OF STAY IN 1b 34 yrs. 5 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 2533 Pennsylvania Ave.					e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Amend Last Amend					4. DATE OF DEATH Month November Day 23 Year 1959						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1898		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Amend					14. MOTHER'S MAIDEN NAME Mary Cecilia Gilmore						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No					16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records Address -				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture, neck right femur DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy with mental deficiency.										INTERVAL BETWEEN ONSET AND DEATH Days 18 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. -					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor						
20c. TIME OF INJURY Month, Day, Year Hour 11/5/ 19 59 a. m. 11/5/ 19 59 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE James T. Marsh					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 11/23/59			
EXAMINER'S NAME (Type) James T. Marsh, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY St. Peter's			22d. LOCATION (City, town, or county) (State) Balto. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Torre						ADDRESS -		24a. REC'D BY REGISTRAR NOV 27 '59		24b. REGISTRAR'S SIGNATURE Charles H. Hines	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-20-1

5

1

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
DATE OF EXAMINATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12394

12409

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 yrs. 11 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Herman Last Appel		4. DATE OF DEATH Month November Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1867
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Appel		14. MOTHER'S MAIDEN NAME Mary Hamel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, simple deterioration			
INTERVAL BETWEEN ONSET AND DEATH days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 19 58 , to November 25, 19 59 , that I last saw the deceased alive on November 25, 19 59 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustini del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/25/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 28/59	22c. NAME OF CEMETERY OR CREMATORY Mt/ Carmel Cem/	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		ADDRESS 2024 Orleans St	
24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE Arthur J. H...	

10/26/19

10/26/19

10/26/19

Dear Mr. [Name],

I am writing to you regarding the [Topic] that we discussed previously. I have reviewed the information and I am pleased to hear that you are interested in [Topic].

I have attached to this letter a copy of the [Document] that you requested. I hope this information is helpful to you. If you have any questions or need further information, please do not hesitate to contact me.

I am looking forward to hearing from you again.

Sincerely,
[Name]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12410

CERTIFICATE OF DEATH

12395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOUIS LEE ARMSWORTHY</u>		4. DATE OF DEATH <u>Nov. 24</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1882</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Springfield Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P. Armsworthy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary A. Armsworthy - wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11. 24</u> , 19 <u>59</u> , to <u>11. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11. 24</u> , 19 <u>59</u> , and that death occurred at <u>6:35</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sani Okutman</u> M.D.		DATE SIGNED <u>37 Central Ave. Highville Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. Sani Okutman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Highville Carroll Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Highville, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS

WINTER

THIRTY

1900

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

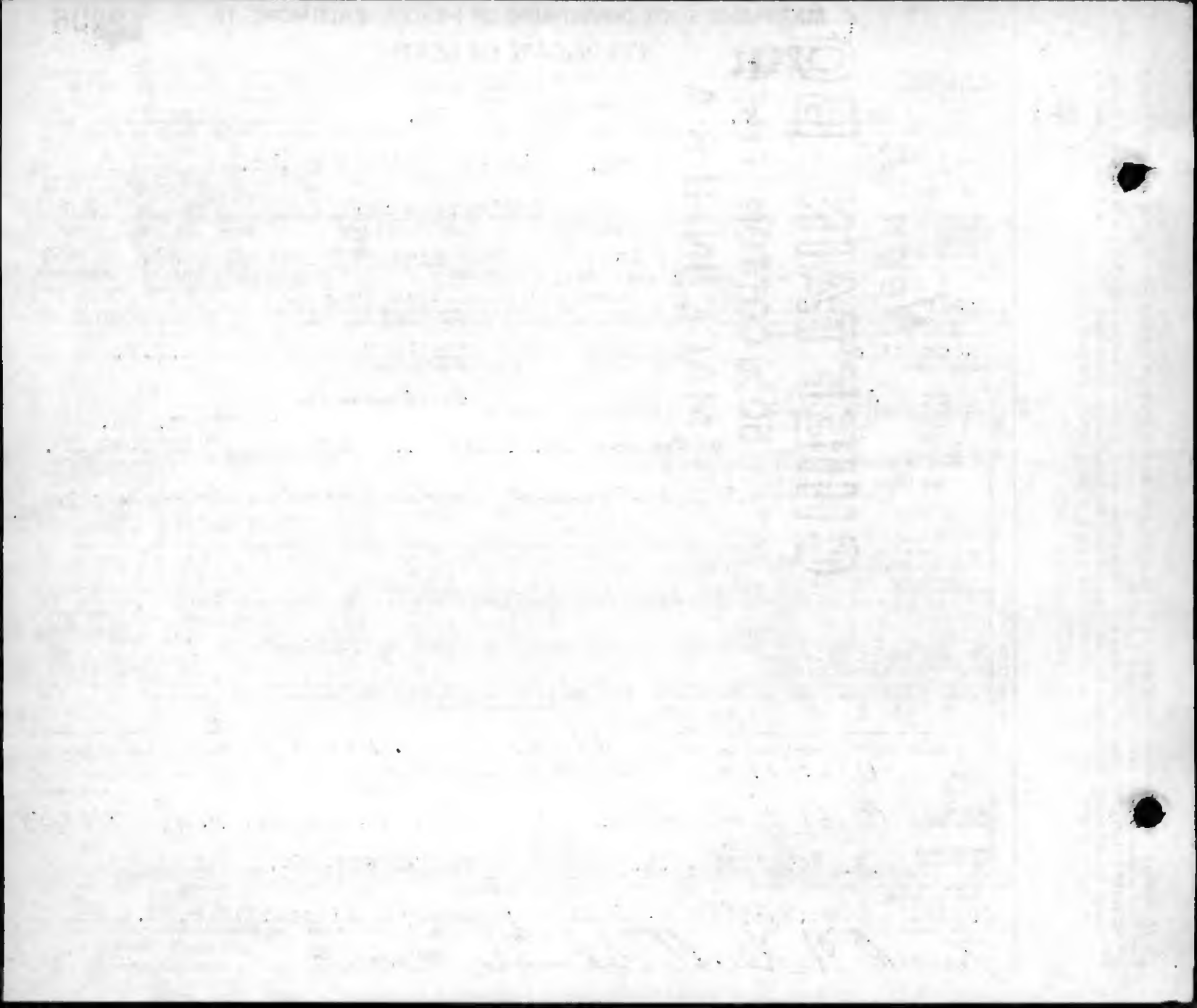
12411

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>		c. LENGTH OF STAY IN lb <u>3 yrs.</u>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown, Md.</u>		d. STREET ADDRESS <u>Uniontown Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Louise</u> Last <u>Berkemeier</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 27, 1880</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Schlegel</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Mr. Calvin C. Berkemeier, Uniontown Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease; years.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11/59</u> , 19 <u> </u> , to <u>11/29/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11/29/59</u> , 19 <u> </u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.				ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>11/29/59</u>			
PHYSICIAN'S NAME (Type) <u>M. E. Robertson, M.D.</u>				New Windsor, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

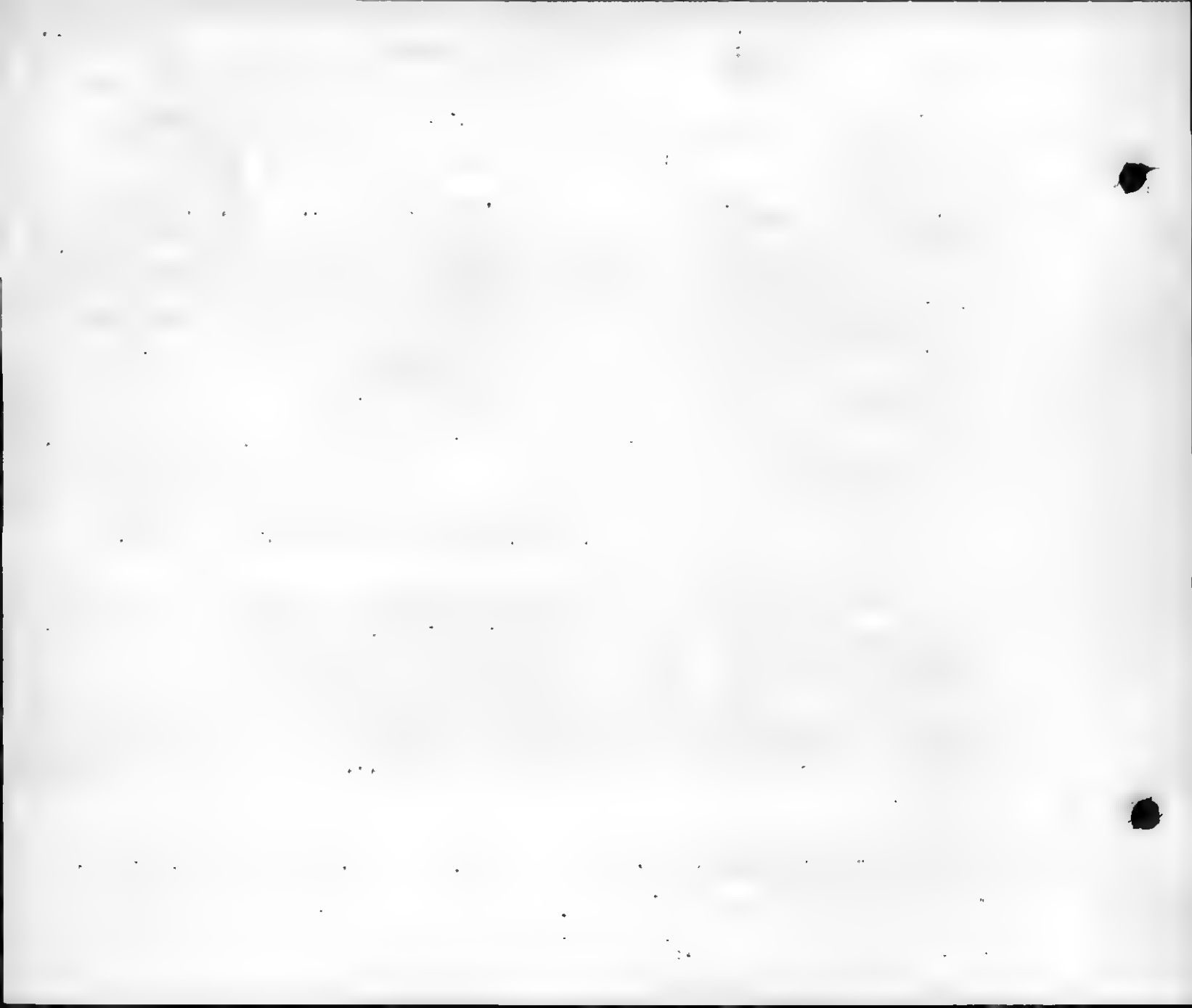
12397

12412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle (Dortch) Last Bortch				4. DATE OF DEATH Month 11 Day 7 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/18	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 11 Days 7 Hours 19 Min. 59	IF UNDER 24 HRS. Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Max Dortch				14. MOTHER'S MAIDEN NAME Jenny Tublan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-38-2018		INFORMANT Records Springfield Hosp. Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Uremia due to subacute glomerulonephritis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Primary behavior disorder; conduct disturbance.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11/2/59 , 19 59 , to 11/7/59 , 19 59 , that I last saw the deceased alive on 11/7/59 , 19 59 , and that death occurred at 3:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital, Sykesville, Md. DATE SIGNED 11/7/59 ACTUAL SIGNATURE Francesco Magro M.D. PHYSICIAN'S NAME (Type) Francesco Magro, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 9-1959		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Bald Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2100 Eutan Place		24a. REG. BY REGISTRAR NOV 10 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna							



12398

Reg. Dist. No.

HOSPITAL OF [REDACTED] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and a copy event within 72 hours after death.

V5 A15 (4)
15M 9/

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL _____) Sykesville		c. LENGTH OF STAY IN 1b 33 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Vol +	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 4 Chestnut Hill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie N. Boughner				4. DATE OF DEATH Month Day Year November 2, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 16, 1881	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Boughner				14. MOTHER'S MAIDEN NAME Mary N. Nicholson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -		INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to November 2, 1959 , that I last saw the deceased alive on November 2, 1959 , and that death occurred at 1:15 PM from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Agustin del Campo M.D. Springfield State Hospital 11/2/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, or other disposition (Specify) burial		22b. DATE THEREOF 11/5/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12414

CERTIFICATE OF DEATH

Reg. Dist. No.

12399

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs. 7mths.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Celestenia Middle Serena Last Brady				4. DATE OF DEATH Month Nov. Day 28 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-1-72	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months 8 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Felix Salter				14. MOTHER'S MAIDEN NAME Martha Crippen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO 104			
17. INFORMANT Mrs. Florence Benson				Address 6103 Walhonding Rd. Glen Echo Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia days 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last (b) Arterio Sclerotic Heart Disease months DUE TO (c) General Arteriosclerosis years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS ALTPSYP PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/25 , 19 59 , to 11/28 , 19 59 , that I last saw the deceased alive on 11/28 , 19 59 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francisco Magro M.D. Springfield State Hosp							
ACTUAL SIGNATURE Francisco Magro							
PHYSICIAN'S NAME (Type) Francisco Magro							
22a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/2/59		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

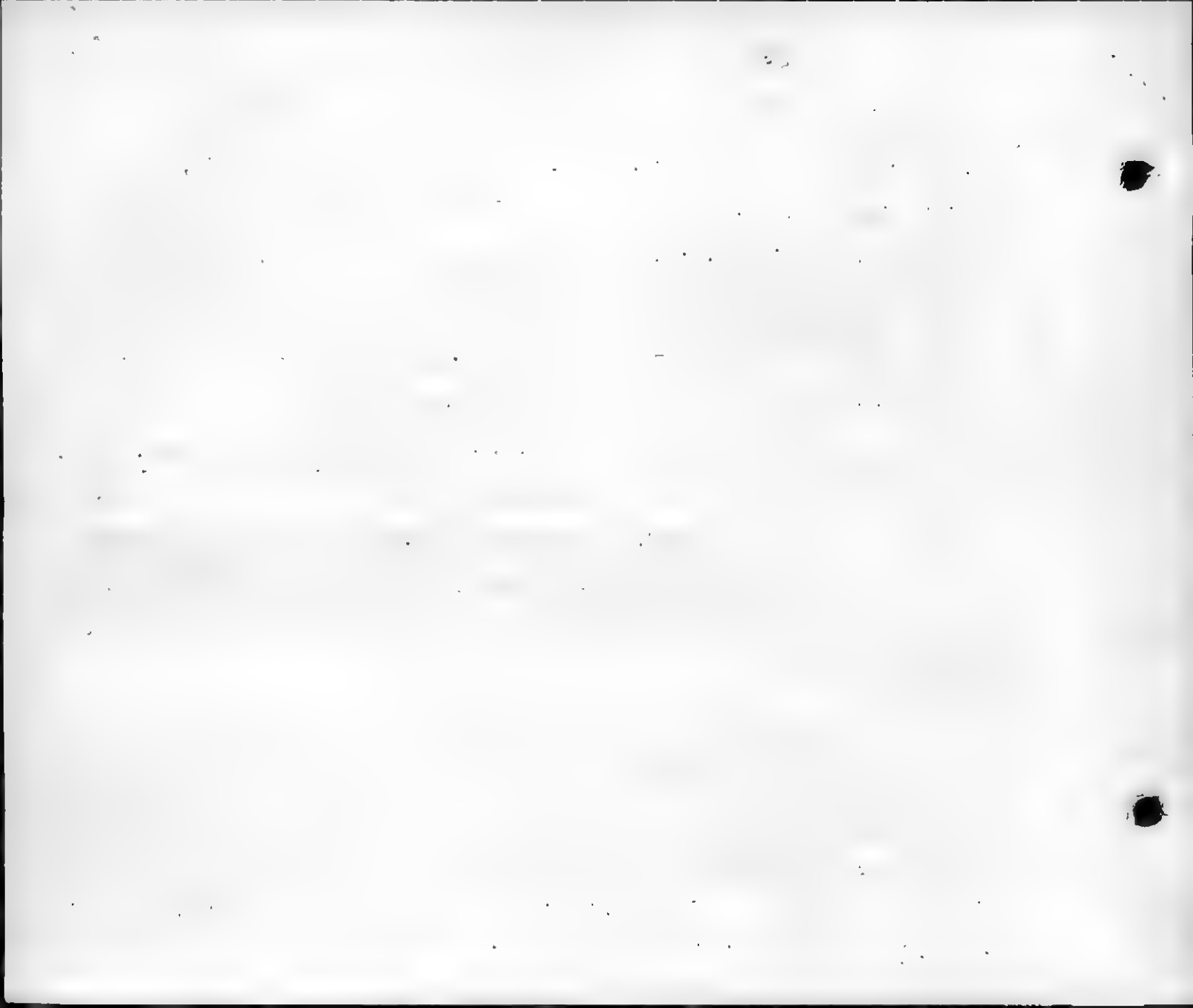
MEDICAL CERTIFICATION

2

1

M

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12415

CERTIFICATE OF DEATH

Reg. Dist. No.

12460

1. PLACE OF DEATH o COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i>		c. LENGTH OF STAY IN 1b <i>17 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>31 Central Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>-</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>11</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 29 1872</i>
9. AGE (In years last birthday) <i>87</i> yrs		10. IF UNDER 1 YEAR: Months <i>21</i> Days <i>-</i> Hours <i>-</i> Min <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Hobbs</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elan Doyle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Oscar L. Hawkins</i>		Address <i>Sylkesville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension, Arteriosclerosis</i> (c) <i>Cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Toxemia, Dehydration</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>-</i>	
20c. TIME OF INJURY Hour <i>-</i> o. m. <i>-</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>	20f. (City or town) (County) (State) <i>-</i>
21. I certify that I attended the deceased from <i>7. 9. 1959</i> to <i>11. 13. 1959</i> , that I last saw the deceased alive on <i>11. 13. 1959</i> , and that death occurred at <i>6:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sani Okutman</i> M.D.		ADDRESS (Street, city or town, state) <i>37 Central Ave Sylkesville Md.</i>	
DATE SIGNED <i>Nov 14 59</i>			
SIGNATURE NAME (Type) <i>Sani A. Okutman</i>		<i>Sylkesville Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>11-15-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Springfield</i>	22d. LOCATION (City, town, or county) (State) <i>Chesapeake, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		ADDRESS <i>Chesapeake, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur H. Haight</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12401

12416

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>15yrs.8mos.17days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Helena</u> Middle <u>Frances</u> Last <u>Bucholtz</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> , Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1921</u>		9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Stickley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral aspiration bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>(Final diagnosis to be determined by toxicological studies.)</u> (c) <u>Psychoneurotic disorder, anxiety reaction.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
James T. Marsh, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or MOVIAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hight</u>				24a. REC'D BY REGISTRAR <u>Nov 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Hight</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10-10-10

7-2-10

10-10-10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12417

CERTIFICATE OF DEATH

12402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Mariettaville</i>	
3. NAME OF DECEASED (Type or print) <i>John William Burke</i>		4. DATE OF DEATH <i>November 8 1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 31, 1901</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Burke</i>		14. MOTHER'S MAIDEN NAME <i>Annie C. Cutsail</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>578-09-1760</i>	
17. INFORMANT <i>William C. Burke</i>		Address <i>Sykesville, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis, Anterior</i> <i>432.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Heart disease, Anterior</i> DUE TO (c) <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1958 to 8/20/59</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8:00 AM</i> 19 <i>1959</i> , to <i>8:00 AM</i> 19 <i>1959</i> , that I last saw the deceased alive on <i>8 Nov</i> 19 <i>1959</i> , and that death occurred at <i>8:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Sykesville, Md</i> DATE SIGNED <i>11-8-59</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		<i>SYKESVILLE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 11, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Providence Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick County, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>		24a. REC'D BY REGISTRAR <i>NOV 12 '59</i> 24b. REGISTRAR'S SIGNATURE <i>William E. Hume</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12418

CERTIFICATE OF DEATH

12403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Mt. Airy	
c. LENGTH OF STAY IN 1b 35 yrs.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Flag Marsh Road	
3. NAME OF DECEASED (Type or print) First ELSIE Middle THOMAS Last DAVIS		4. DATE OF DEATH Month Nov. Day 6 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-17-1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John E. Davis		14. MOTHER'S MAIDEN NAME Linda E. Hatfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. August E. Davis,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of stomach and DUE TO General Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 4, 1959 to Nov 6, 1959 , that I last saw the deceased alive on Nov 5, 1959 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C M Van Pool M.D. Nov 6, 1959 C M Van Pool			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-9-1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive
22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland		23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE NOV 10 1959		24b. REGISTRAR'S SIGNATURE C. M. Waltz	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12404

Reg. Dist. No. 74

12419

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION En route to Henryton State Hosp.				d. STREET ADDRESS 517 E. 23rd Street			
3. NAME OF DECEASED (Type or print) First Benjamin Middle Hill Last Dudley				4. DATE OF DEATH Month Nov. Day 24 Year 1959			
5. SEX. Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-23-1898	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Raleigh, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Harriet Dudley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Enid Dudley - Same as patient			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diphtheria DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diphtheria DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 18 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/24/59							
ACTUAL SIGNATURE James J. Marsh, Deputy Med Examiner				PHYSICIAN'S NAME (Type) JAMES J. MARSH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Erroy C Wilson - 1000 Broadway				24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Fennell	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as file burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

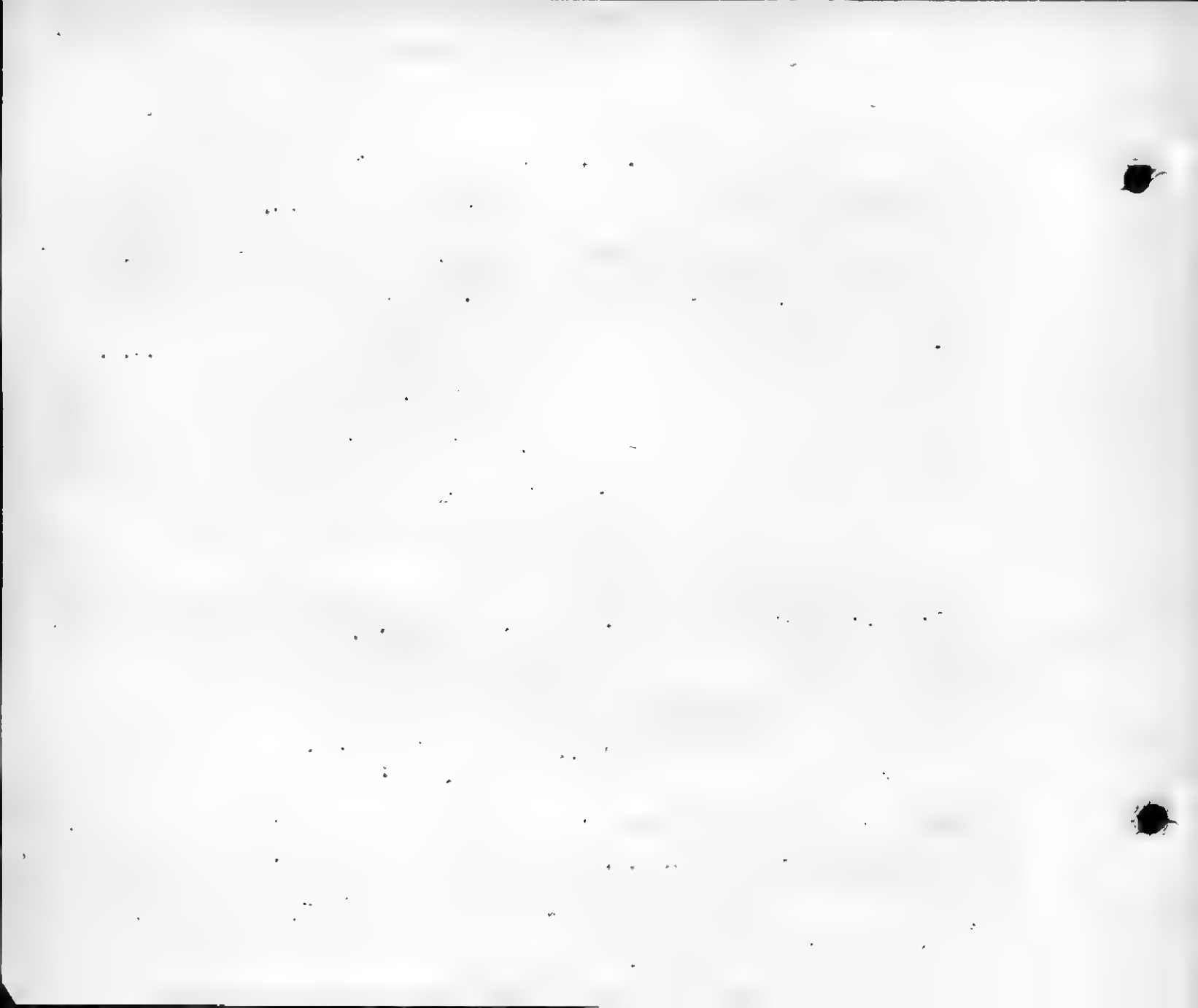
12420

CERTIFICATE OF DEATH

12405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 30yrs. 1mo. 16days Baltimore 03x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3508 Forrest Hill Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Winkler Last Emrine				4. DATE OF DEATH Month November Day 20, Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1892	
9. AGE (In years lost birthday) 67		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -			
13. FATHER'S NAME Alvin Winkler				14. MOTHER'S MAIDEN NAME Walburga Tuchholl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy with mental deficiency. Diabetes Mellitus.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 12:45AM				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 7, 1955 to November 20, 1959 that I last saw the deceased alive on November 19, 1959 and that death occurred at 12:45AM from the causes and on the date stated above.							
22. ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Agustin del Campo M.D.				Springfield State Hospital 11/20/59			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) BALTIMORE, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. L. Schwab FUNERAL HOME Francis N. Galloway 2101 Frederick Ave. Balt. Md.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12404

CERTIFICATE OF DEATH

Reg. Dist. No. 12406

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b years 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 74 RALPH ST		d. STREET ADDRESS 74 Ralph St	
3. NAME OF DECEASED (Type or print) First CHARLES Middle L Last ENDERS		4. DATE OF DEATH Month Nov Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1885
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret'd Machinist		10b. KIND OF BUSINESS OR INDUSTRY Franklin Balmar Corporation	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-2754	
17. INFORMANT Address Marie J. Enders, Westminster, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Embolism of the heart DUE TO AS.C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 to 11-24 , 19 59 , that I last saw the deceased alive on 11-24 , 19 59 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 11-24-59			
ACTUAL SIGNATURE James J. Sharon M.D.		PHYSICIAN'S NAME (Type) JAMES T. MARSH	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-27-59	22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden	22d. LOCATION (City, town, or county) (State) Carroll County, Md
23. FUNERAL DIRECTOR'S SIGNATURE Will am Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE NOV 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL CHIEF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12407

12421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3801 4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 13,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>3531 Lyndale Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Joseph</u> Last <u>Fleischman</u>				4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/94</u>	9. AGE (In years last birthday) <u>65</u> yrs	IF UNDER 1 YEAR Months <u>05</u> Days <u>05</u> Hours <u>05</u> Min <u>05</u>	IF UNDER 24 HRS. Months <u>05</u> Days <u>05</u> Hours <u>05</u> Min <u>05</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Fleischman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth--- Geiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Hospital Records Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO <u>Syphilitic Aortitis</u> DUE TO <u>Hypertensive cardiovascular disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic with psychotic reaction.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>more than 1 yr.</u> <u>more than 5 years.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year <u>Hour a. m. 19</u> <u>p. m.</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20 19 59</u> to <u>Nov. 4 19 59</u> , that I last saw the deceased alive on <u>Nov. 4 19 59</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11-1-59</u> DATE SIGNED <u>11-1-59</u>							
ACTUAL SIGNATURE <u>Walter Knopp</u> M.D.				PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Brehms Lane</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

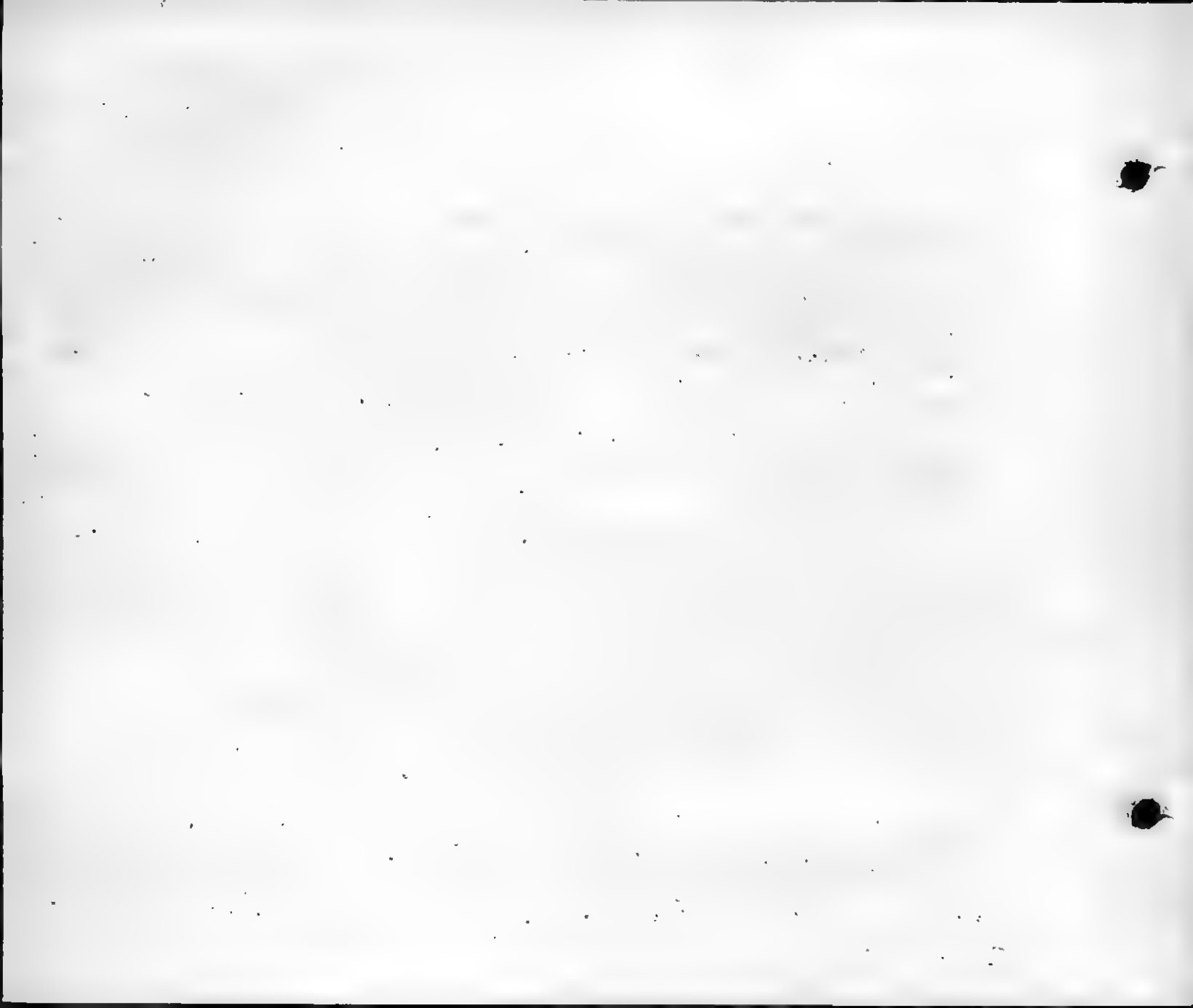
12422

CERTIFICATE OF DEATH

Reg. Dist. No.

12408

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>LEVI</i> Middle <i>J</i> Last <i>Forrester</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-16-1889</i>
9. AGE (In years last birthday) <i>70</i> yrs		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto Transit</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Philmore Forrester</i>		14. MOTHER'S MAIDEN NAME <i>Arabella Hendley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>213-10-1488</i>	
17. INFORMANT <i>Jackson Forrester</i>		Address <i>Manchester Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Anterior & lateral Heart Disease</i> DUE TO (c) <i>5 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1950</i> to <i>1959</i> , that I last saw the deceased alive on <i>Nov 13</i> , 1959, and that death occurred at <i>1:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H Forrester</i> M.D.		ADDRESS (Street, city or town, state) <i>25 S Main St, Manchester, Md</i> DATE SIGNED <i>11-17-59</i>	
PHYSICIAN'S NAME (Type) <i>W H Forrester</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-16-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baptist Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Manchester Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Dutton</i> ADDRESS <i>Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kenna</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12409

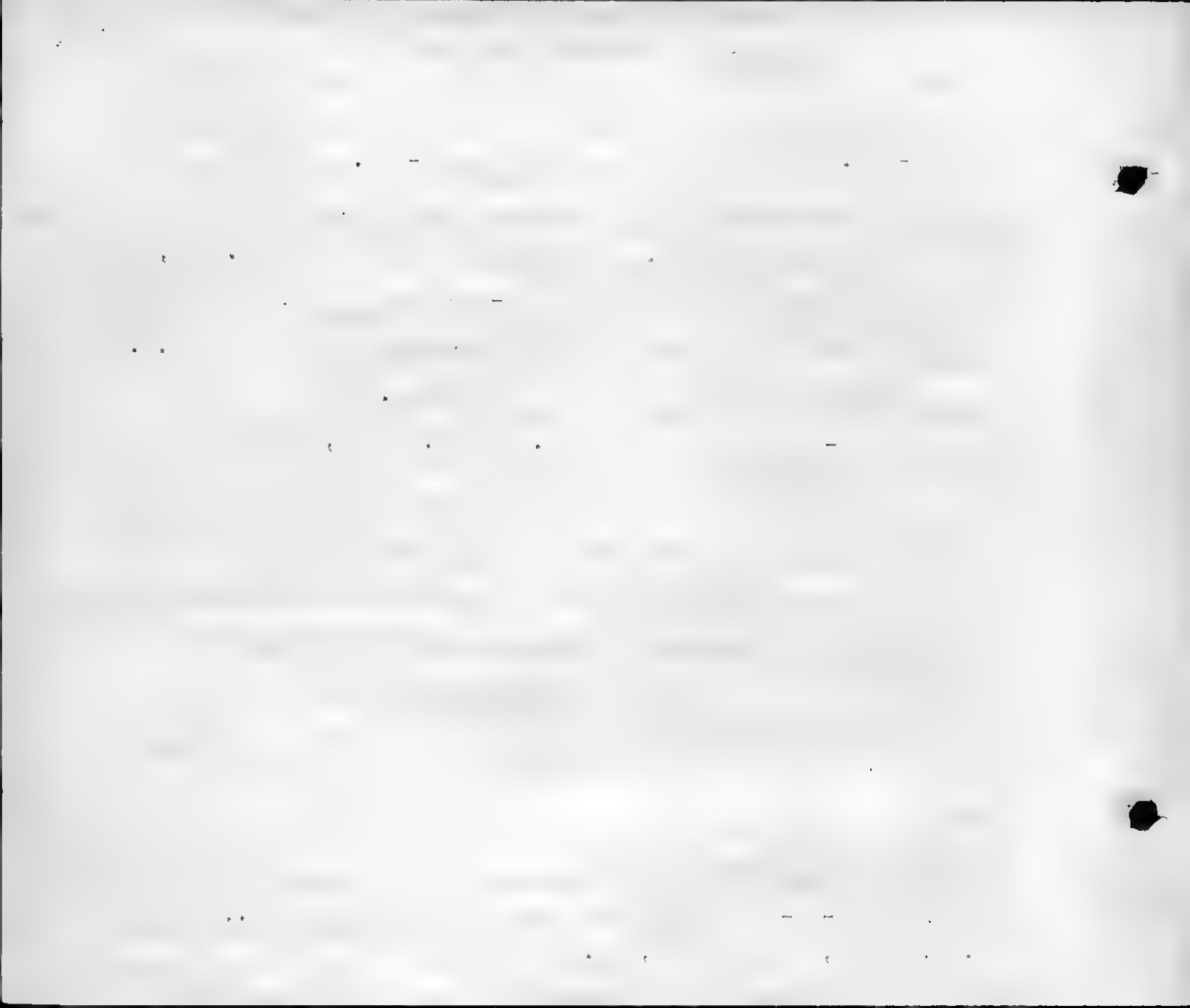
Reg. Dist. No.

12423

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/ d. STREET ADDRESS Rt 27		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last FRANKLIN				4. DATE OF DEATH Month NOV. Day 9, Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-1867		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY own		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nathan Franklin				14. MOTHER'S MAIDEN NAME Martha E. ??			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Olin Franklin, same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X General debility from age DUE TO (b) Hypertension (Arterio Sclerosis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 23, 1959 to Nov 9, 1959 that I last saw the deceased alive on Oct 23, 1959 and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. M. Van Boele M.D.				DATE SIGNED 11-9-59			
PHYSICIAN'S NAME (Type) C. M. Van Boele							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-12-1959		22c. NAME OF CEMETERY OR CREMATORY Taylorsville		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12424

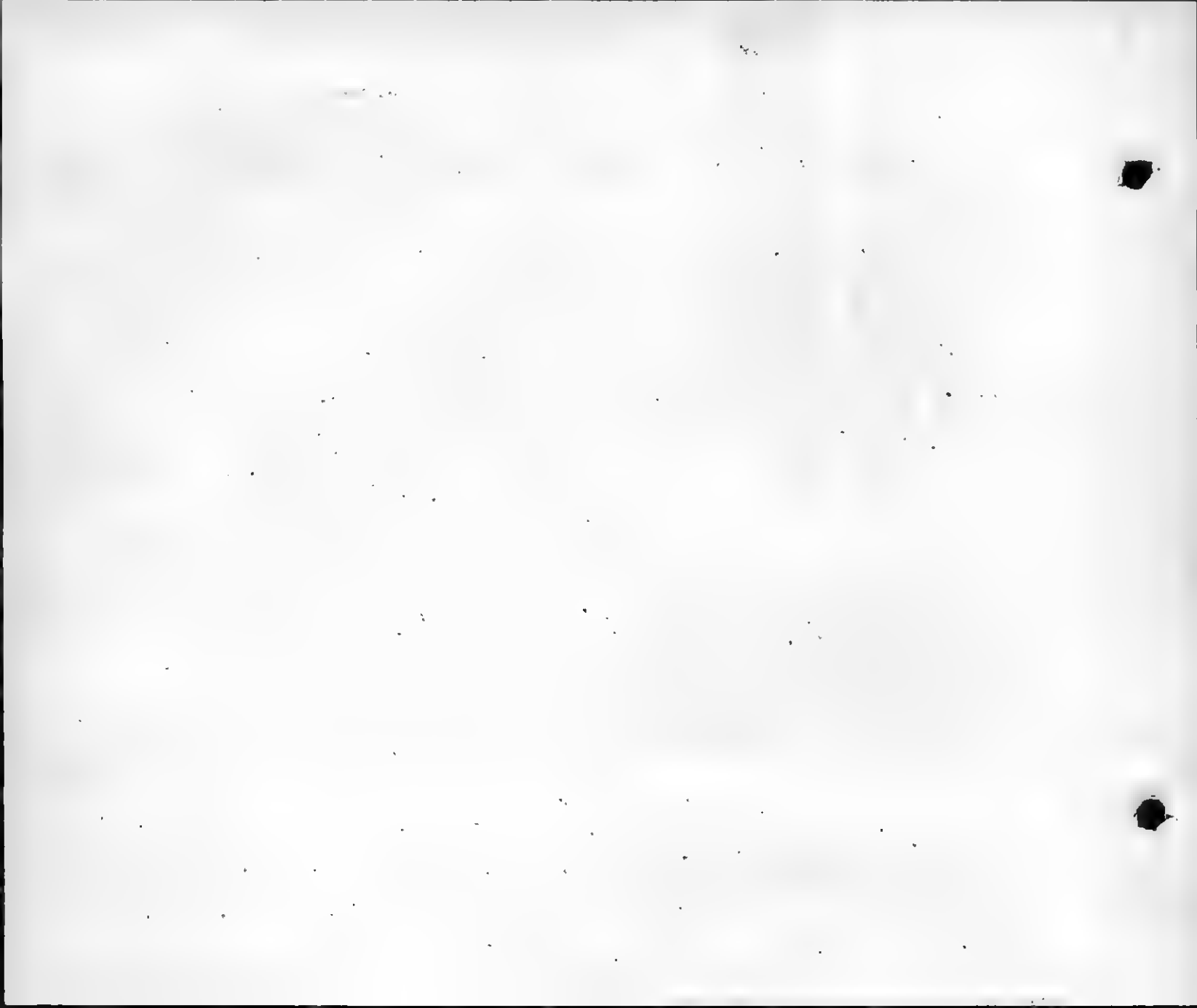
CERTIFICATE OF DEATH

12410

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Rural</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Doss - M - GARLAND</i>		4. DATE OF DEATH <i>Nov 10 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 30 - 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	9. AGE (In years last birthday) <i>82</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles W Garland</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Garland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>240</i>	
17. INFORMANT <i>Mrs John Spindle</i>		Address <i>Hampstead Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cremay Carcinoma Prostate</i> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis Cardiovascular Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, b dg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1</i> , 19 <i>57</i> to <i>Nov 10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov 10</i> , 19 <i>59</i> , and that death occurred at <i>5:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph E Bush M.D.</i>		ADDRESS (Street city or town, State) <i>Hampstead Maryland</i>	
PHYSICIAN'S NAME (Type or print) <i>Joseph E Bush M.D.</i>		DATE SIGNED <i>11-11-59</i>	
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-13-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hampstead</i>		22d. LOCATION (City, town, or county) (State) <i>Carroll co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Tipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR <i>Nov 13 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and #2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

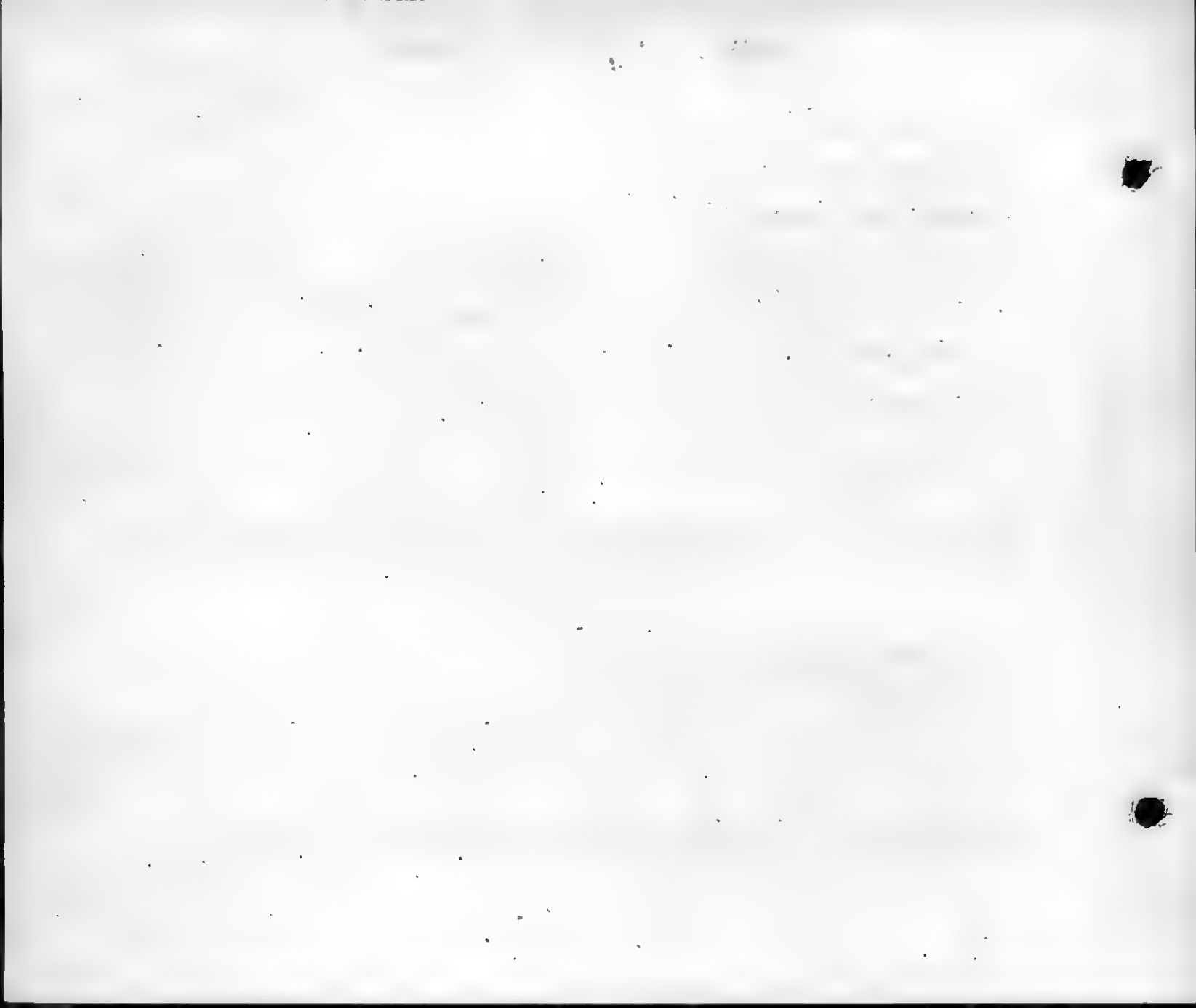
12425

CERTIFICATE OF DEATH

12411

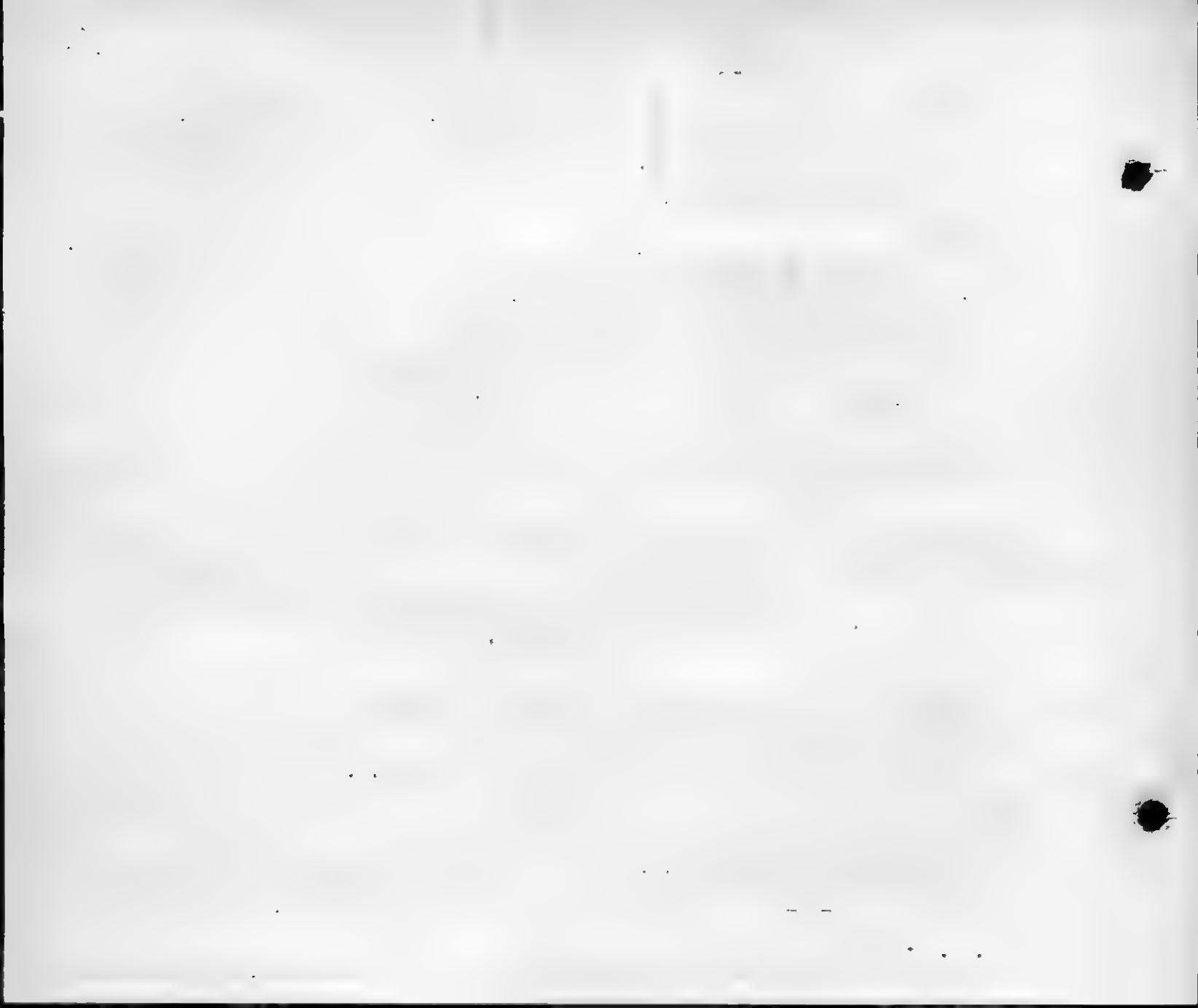
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> c. LENGTH OF STAY IN 1b <u>8 mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Loughgreen Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> d. STREET ADDRESS <u>22 N Main</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA</u> <u>I</u> <u>GARRETT</u>		4. DATE OF DEATH Month Day Year <u>Nov</u> <u>14</u> <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward W Wine</u>		14. MOTHER'S MAIDEN NAME <u>Louise Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Paul R Garrett</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>Nov 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jay E Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>11-14-59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E Bush</u>		<u>HAMPSTEAD MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McAlister</u>	22d. LOCATION (City, town, or county) (State) <u>Hannover Prussia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edna C Tipton</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thoma</u>	



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

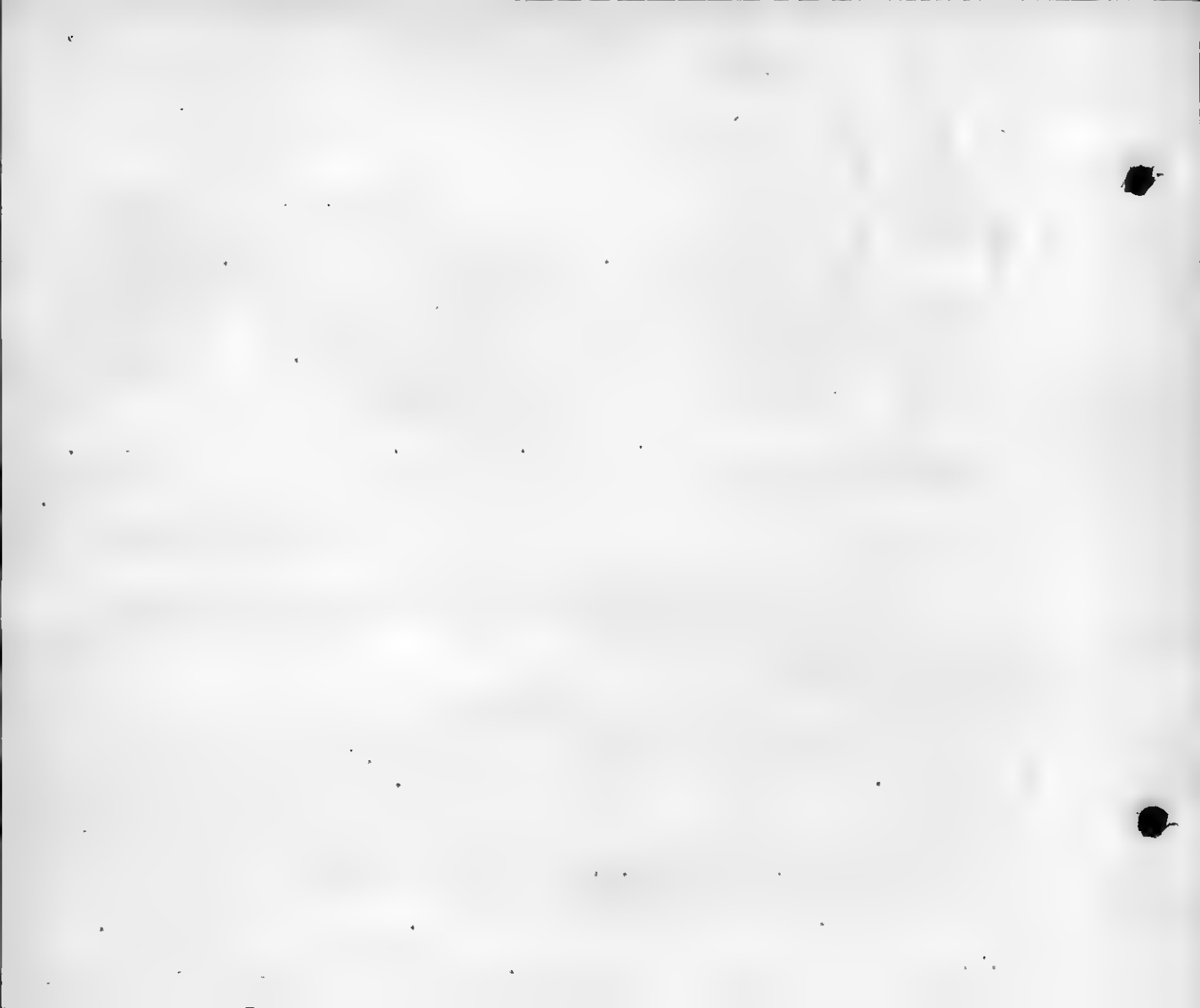
12413

12427

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
c. LENGTH OF STAY IN 1b Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Finksburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Murray Road		d. STREET ADDRESS Murray Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Chloe Middle C. Last Grafton		4. DATE OF DEATH Month Nov. Day 25 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1871
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months 8 Days 8 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Forest Hill, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kean		14. MOTHER'S MAIDEN NAME Street DeVoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Harry E. Ward		Address Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) 15 mins.			INTERVAL BETWEEN ONSET AND DEATH 15 mins.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1957 to Nov. 25 1959 , that I last saw the deceased alive on Nov. 18 1959 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street	
DATE SIGNED 11-27-59			
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 28, 59	22c. NAME OF CEMETERY OR CREMATORY Old Brick Church Cem.	22d. LOCATION (City, town, or county) Jarrettsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR NOV 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

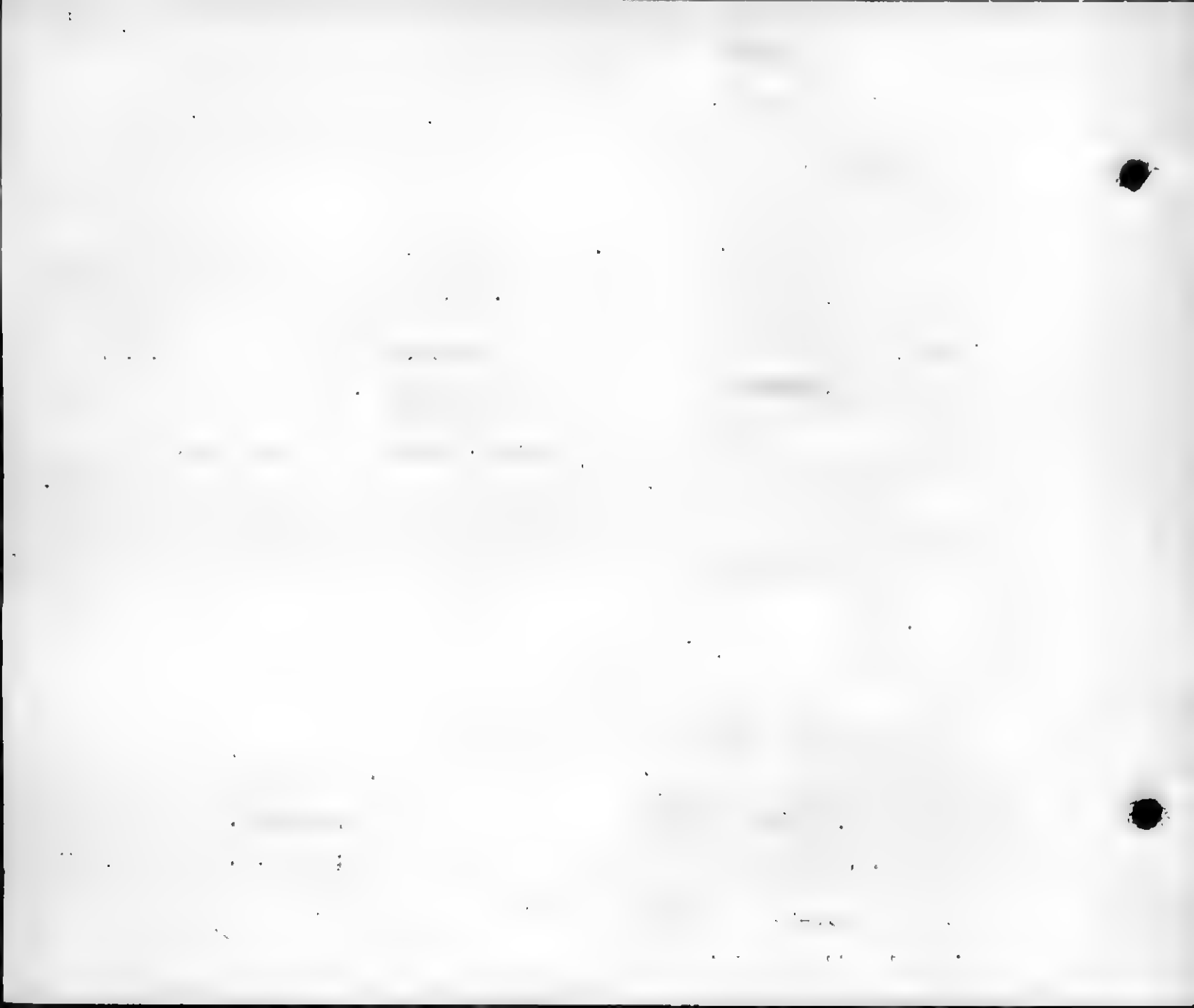
12428

CERTIFICATE OF DEATH

12414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead		c. LENGTH OF STAY IN 1b Hampstead	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle M. Last Gutridge		4. DATE OF DEATH Month November Day 5 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1926
9. AGE (In years last birthday) 32 yrs		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry E. Kohls		14. MOTHER'S MAIDEN NAME Catherine L. Prietz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
INFORMANT Henry E. Kohls		Address Hampstead, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rheumatic Heart Disease DUE TO (c) 2 years			INTERVAL BETWEEN ONSET AND DEATH 5 Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Angina Pectoris 1/2 year			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/14/59 , 19 59 , to 11/5 , 19 59 , that I last saw the deceased alive on 11/4/59 , 19 59 , and that death occurred at 10:45 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. C. Porterfield		ADDRESS (Street, city or town, state) Hampstead, Md. 11/7/59	
PHYSICIAN'S NAME (Type) M. C. Porterfield		Hampstead, Md. 11/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-9-59	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) 3310 Taylor Ave
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Ok, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
		24b. REGISTRAR'S SIGNATURE William S. Frank	



12405

CERTIFICATE OF DEATH

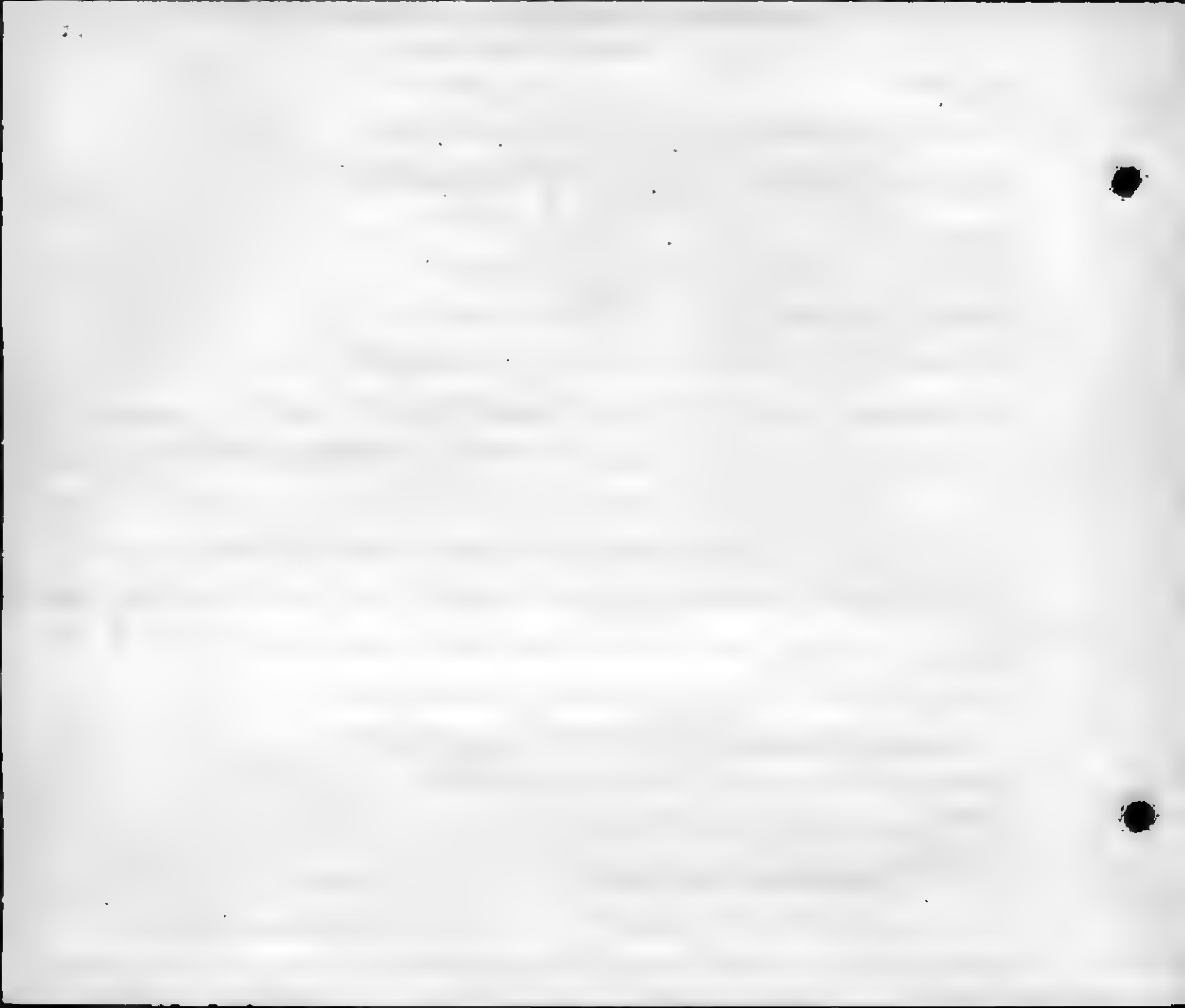
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>60 East Main St.</u>				d. STREET ADDRESS <u>60 E Main St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY HIRSH HARBALUGH II</u>				4. DATE OF DEATH Month Day Year <u>November 18 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15 1910</u>	
9. AGE (In years last birthday) <u>49</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Operator & Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster, Md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry H. Harbaugh III</u>				14. MOTHER'S MAIDEN NAME <u>Sally Feagle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>213-69-9156</u>		17. INFORMANT <u>Egon W. Harbaugh, Westminster, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>35 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>11/18</u> , 19 <u>59</u> , to <u>11/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>59</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James I. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>1058 Main St</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>				DATE SIGNED <u>11/19/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery, Westminster, Md</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Meyer, Jr. Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pinner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12429

CERTIFICATE OF DEATH

12416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARRIE ESTELLE HAWKINS</u>		4. DATE OF DEATH <u>Nov. 13 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse S. Brandenburg</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. & Mrs. Howard E. Hall</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerotic heart disease</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1955 to 13 Nov 1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>13 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 Nov</u> , 19 <u>59</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>13 Nov 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 18 1959</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Haight</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12430

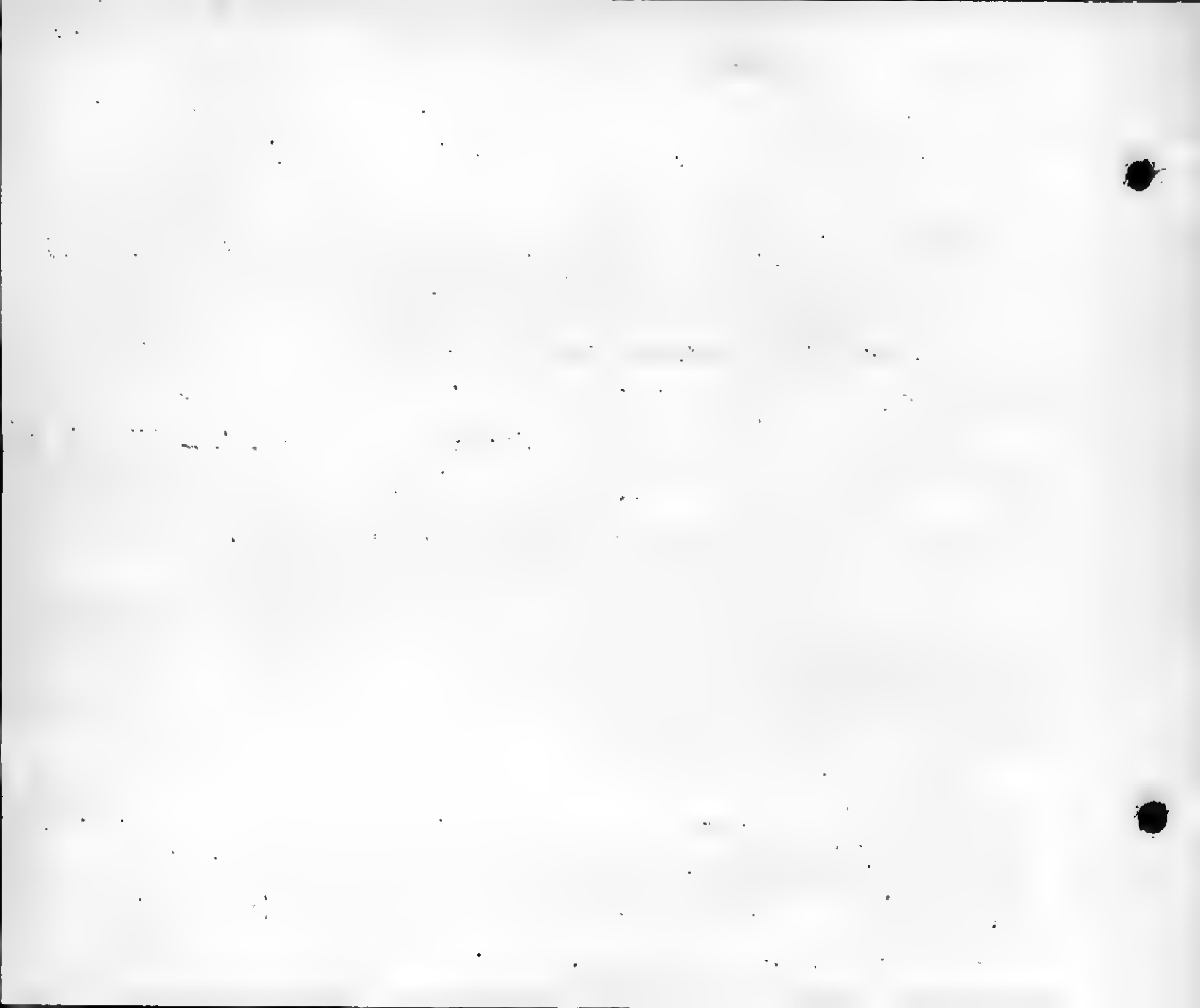
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Barnell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BIRDIE - HOFFACKER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>FF</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>12</u> Hours <u>19</u> Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George W Hoffacker</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Lundeos</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO <u>215-07-1613</u>		INFORMANT <u>Mrs Harney Rhodes Westminster, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>5 yr</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>Nov 12</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>Oct</u> , 19 <u>59</u> ; and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H F Oard</u> M.D.		DATE SIGNED <u>11/13/59</u>	
PHYSICIAN'S NAME (Type) <u>W H F Oard M.D.</u>		<u>Manchester, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-15-59</u>	<u>Manchester</u>	<u>Barnell Co</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw & Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<u>NOV 17 '59</u>		<u>Arthur A. Thomas</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

12431

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

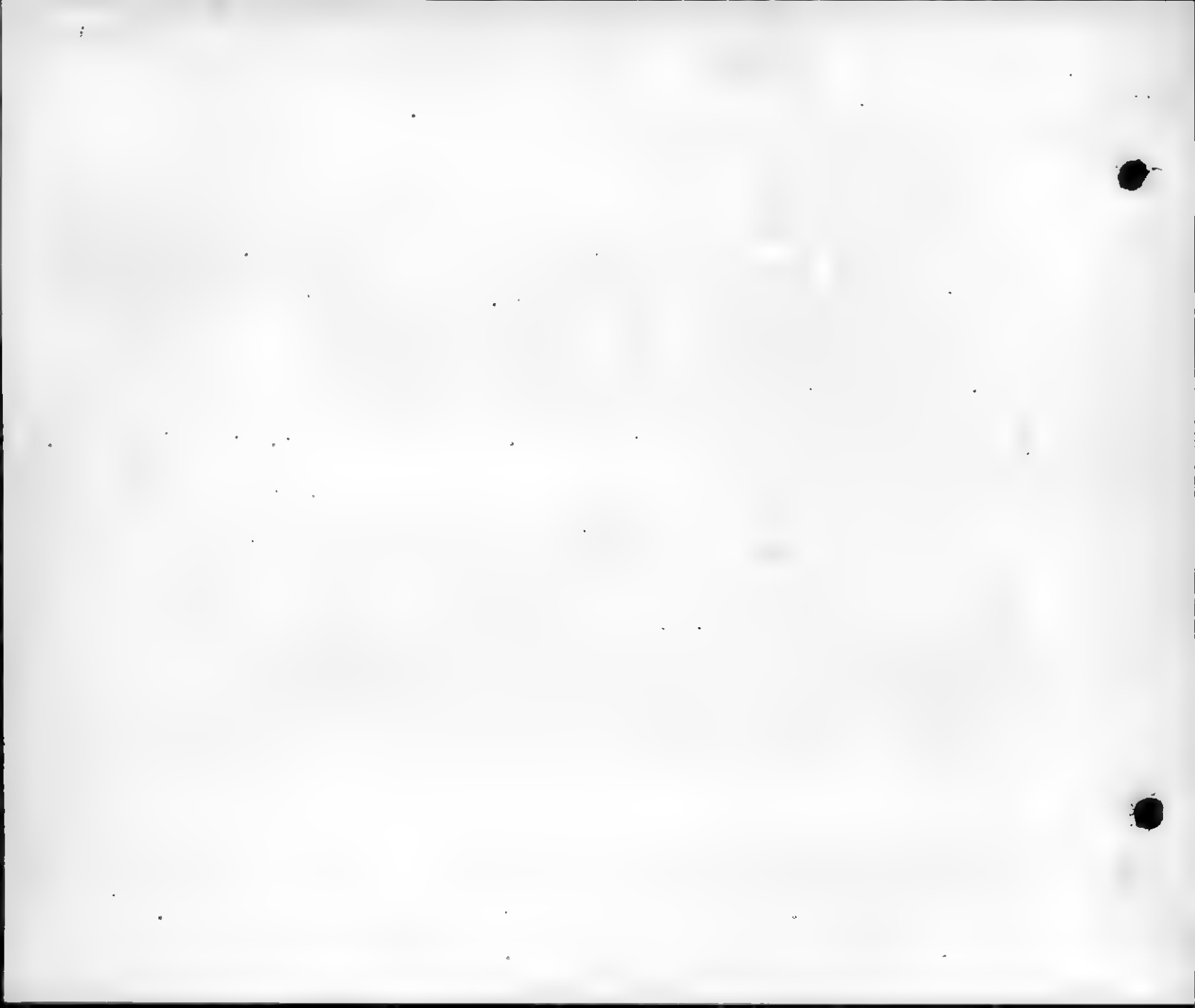
12418

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Finksburg d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mina Middle L. Last Hubbard		4. DATE OF DEATH Month Nov. Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1870
9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min 1	11. IF UNDER 24 HRS Months 8 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Asplen		14. MOTHER'S MAIDEN NAME Charlotte Lenthicium	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Gist Jr.		Address Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac disease for 5 years or more DUE TO Cardiovascular Disease (chronic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Disease (chronic) DUE TO Cardiovascular Disease (chronic) (c) Cardiovascular Disease (chronic)			INTERVAL BETWEEN ONSET AND DEATH 5 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 770			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 770	
20c. TIME OF INJURY Month, Day, Year Hour a. m. X 19 p. m. X	20d. INJURY OCCURRED While at work <input type="checkbox"/> No while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) X	20f. (City or town) X (County) (State)
21. I certify that I attended the deceased from Oct 1, 1959 to 11-28, 1959 , that I last saw the deceased alive on 11-24, 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Md. DATE SIGNED me			
ACTUAL SIGNATURE W. E. Storer		M.D. W. E. Storer	
PHYSICIAN'S NAME (Type) W. E. Storer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1, 1959	22c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery	22d. LOCATION (City, town, or county) (State) Finksburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12419

12432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. COUNTY Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4 y. 8 mo. 3 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3625 Columbia Drive	
3. NAME OF DECEASED (Type or print) First Cyries Middle Dorothy Last Kellner		4. DATE OF DEATH Month November Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-08
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 10 Hours 19 Min 59	11. IF UNDER 24 HRS Months 51 Days 10 Hours 19 Min 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Gainfully Emp.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emmanuel Kellner Deceased		14. MOTHER'S MAIDEN NAME Mollie Kellner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield State Hospital Records		Address Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Neoplasm in the Intestines. 230X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ulcerative Colitis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Convulsive Seizures		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 19 55 , to November 10, 19 59 that I last saw the deceased alive on November 10, 19 59 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ilse Kamm, M.D.		DATE SIGNED November 10, 1959	
PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.		ADDRESS (Street, city or town, state) Sykesville, Maryland	
22a. B. RIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12-1959	
22c. NAME OF CEMETERY OR CREMATORY Adas Israel Cem		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
24b. REGISTRAR'S SIGNATURE Carlton & Kram		24c. REGISTRAR'S SIGNATURE Carlton & Kram	



CERTIFICATE OF DEATH

Reg. Dist. No.

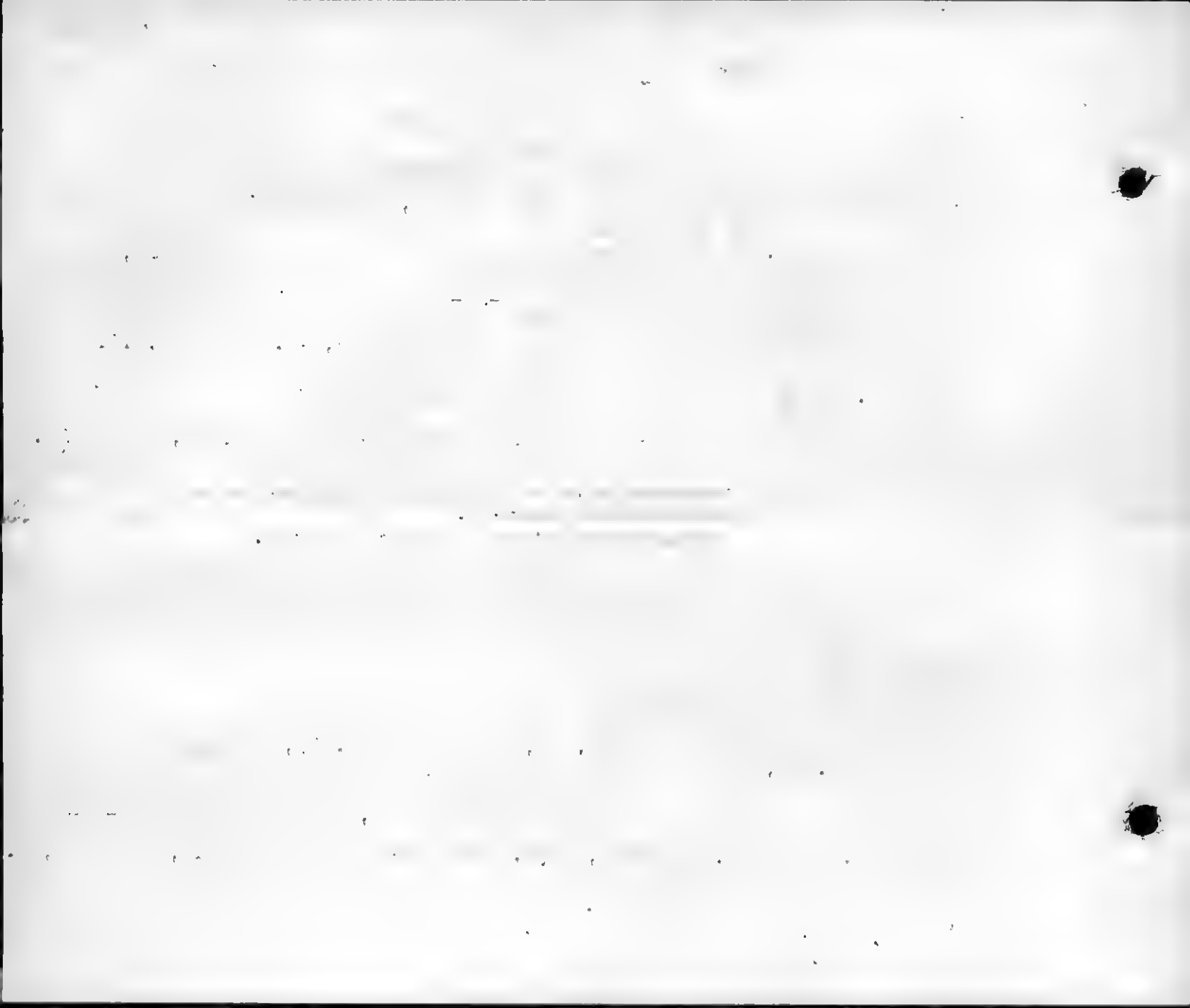
12433

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville d. STREET ADDRESS Box 6, Batson Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Theodore Kelly		4. DATE OF DEATH Month Day Year 11 27, 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1890
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Spencerville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nelson E. Kelly		14. MOTHER'S MAIDEN NAME Selena Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Eleanor Smith - Niece		Address Box 6, Batson Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident due to hypertensive 44 DUE TO cardiovascular disease. Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Undiagnosed minimal pulmonary disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 25, 1959 to Nov. 27, 1959 that I last saw the deceased alive on Nov. 27, 1959 and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Henryton, Maryland 11-27-59 ACTUAL SIGNATURE Edgars M. Maculans M.D. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11/30/59	Spencerville Cem. Spencerville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sander		24a. REC'D BY REGISTRAR Lochell Rd 24b. REGISTRAR'S SIGNATURE Catherine S. Hays DATE NOV 30 '59	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



CERTIFICATE OF DEATH

12422

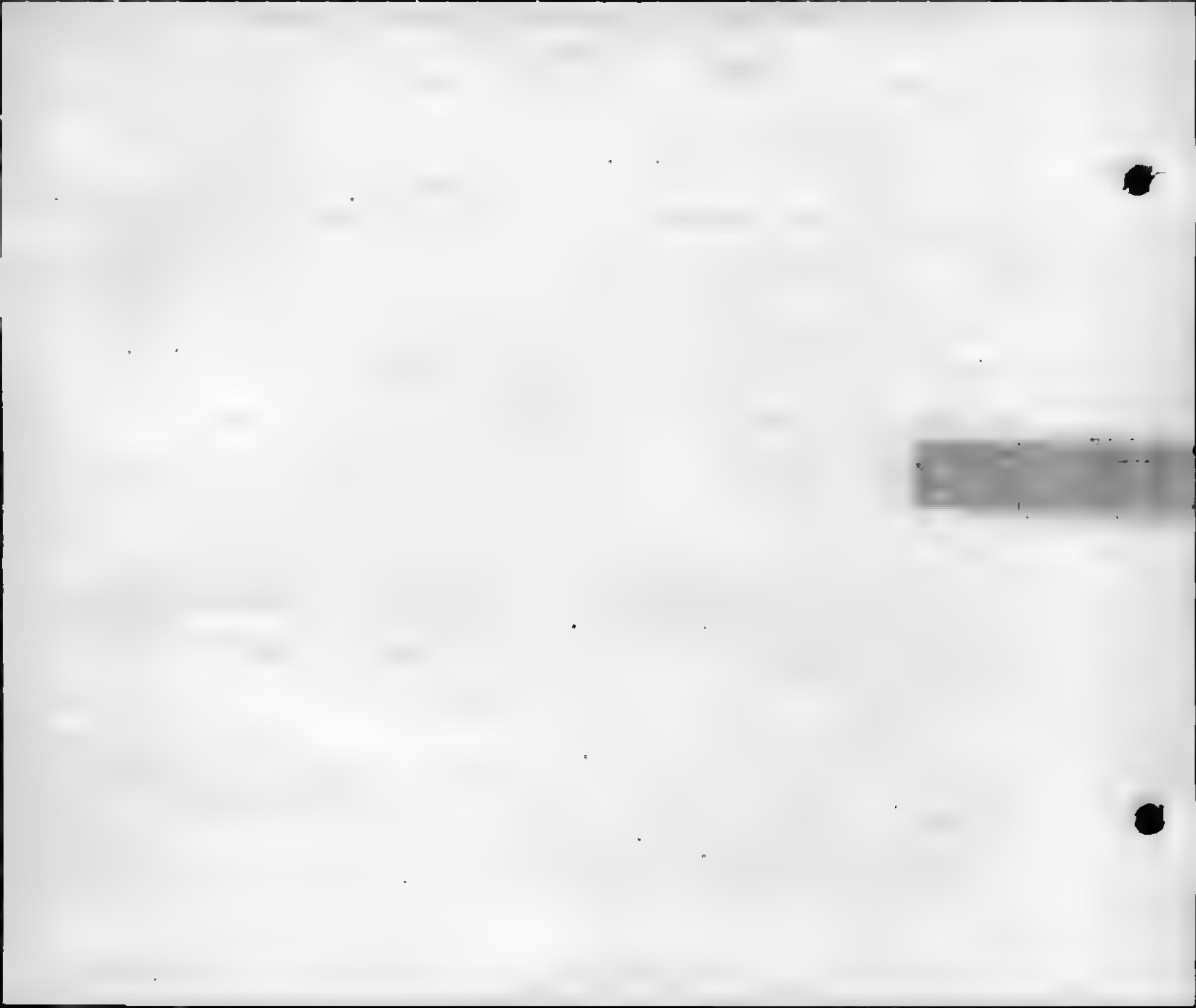
Reg. Dist. No.

12435

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 5yr. 2mo. 14da.		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before adm-ss on) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 2415 Fleet St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Benedict Thomas Krug		4. DATE OF DEATH Month Day Year 11 12 1959		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-21-92		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Germanian		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Krug		14. MOTHER'S MAIDEN NAME Madeline Gast		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. (If not, give year or dates of service) 1918 unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH more than 12 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, undifferentiated.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sykesville, Maryland		(County)		(State)					
21. I certify that I attended the deceased from Aug. 1955, 19 to 11-12-1959 that I last saw the deceased alive on 11-12-59, 19 and that death occurred at 7:30 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED					
ACTUAL SIGNATURE Walter Knopp, M.D.		PHYSICIAN'S NAME (Type) Walter Knopp, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 211 Dundalk Ave.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Clifford A. Knapp			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
c. LENGTH OF STAY IN TB <u>Life</u>		d. STREET ADDRESS <u>78 Main St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles A. KOKLES</u>		4. DATE OF DEATH <u>November 10 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	11. BIRTHPLACE (State or foreign country) <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Kokes</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Whittman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>W.W. I & II</u>	
16. SOCIAL SECURITY NO. <u>91-4411</u>		17. INFORMANT <u>Mrs Minnie Kokes - Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIORAL NEPHROSCLEROSIS, MALIGNANT</u> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> to <u>Nov. 10 1959</u> , that I last saw the deceased alive on <u>Nov. 9 1959</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>11/10/59</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville-2, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Hight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hight</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12423

12436

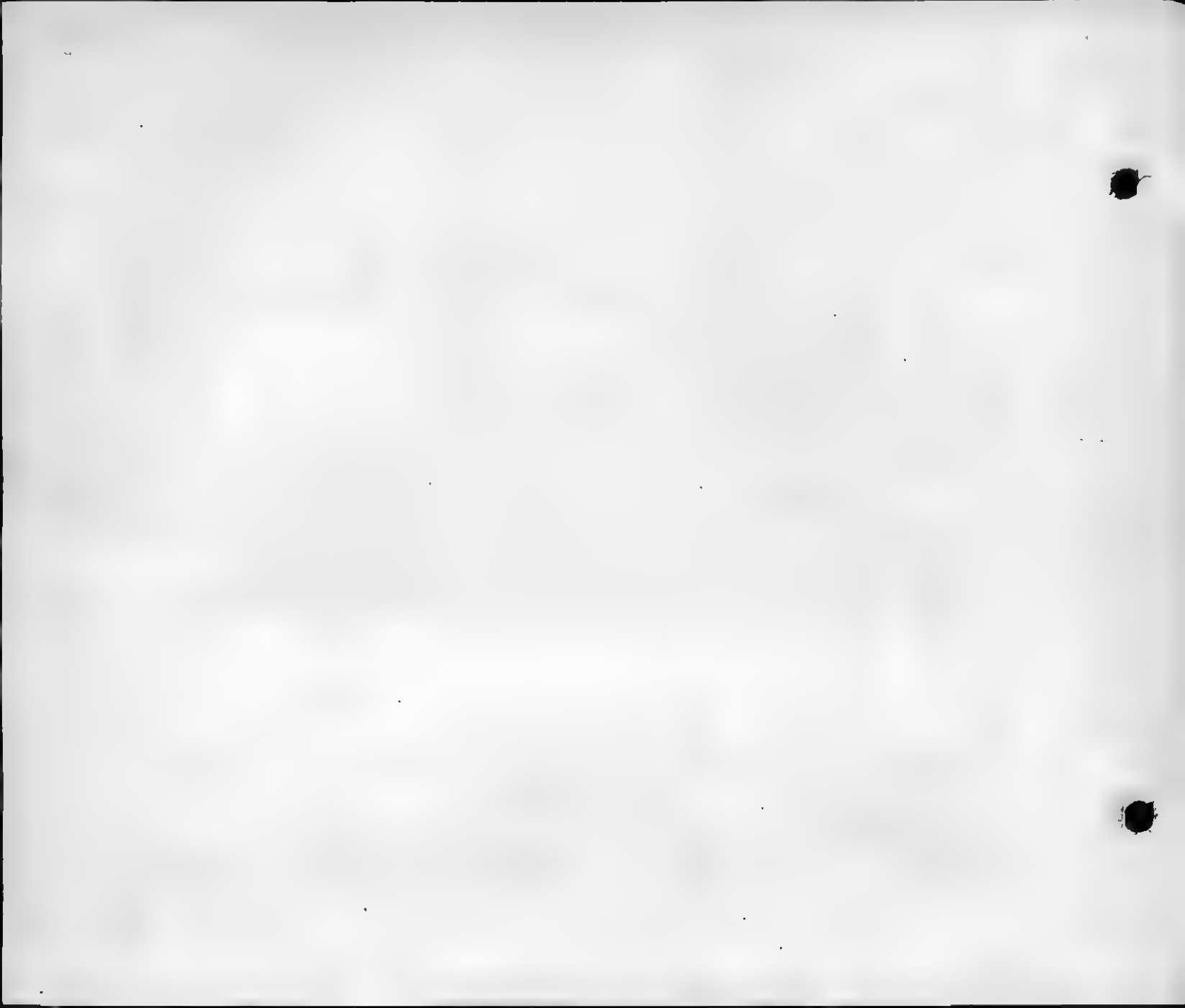
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Harroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY <u>Harroll</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs</u>		d. STREET ADDRESS <u>Westminster Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES - A - MAHANNA</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1895</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>15</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E Mahanna</u>		14. MOTHER'S MAIDEN NAME <u>Ella Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Vernon Mahanna</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Sudden several yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. L. Speicher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. L. Speicher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leister</u>		22d. LOCATION (City, town, or county) (State) <u>Harroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw H Tipton</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 20 '59</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

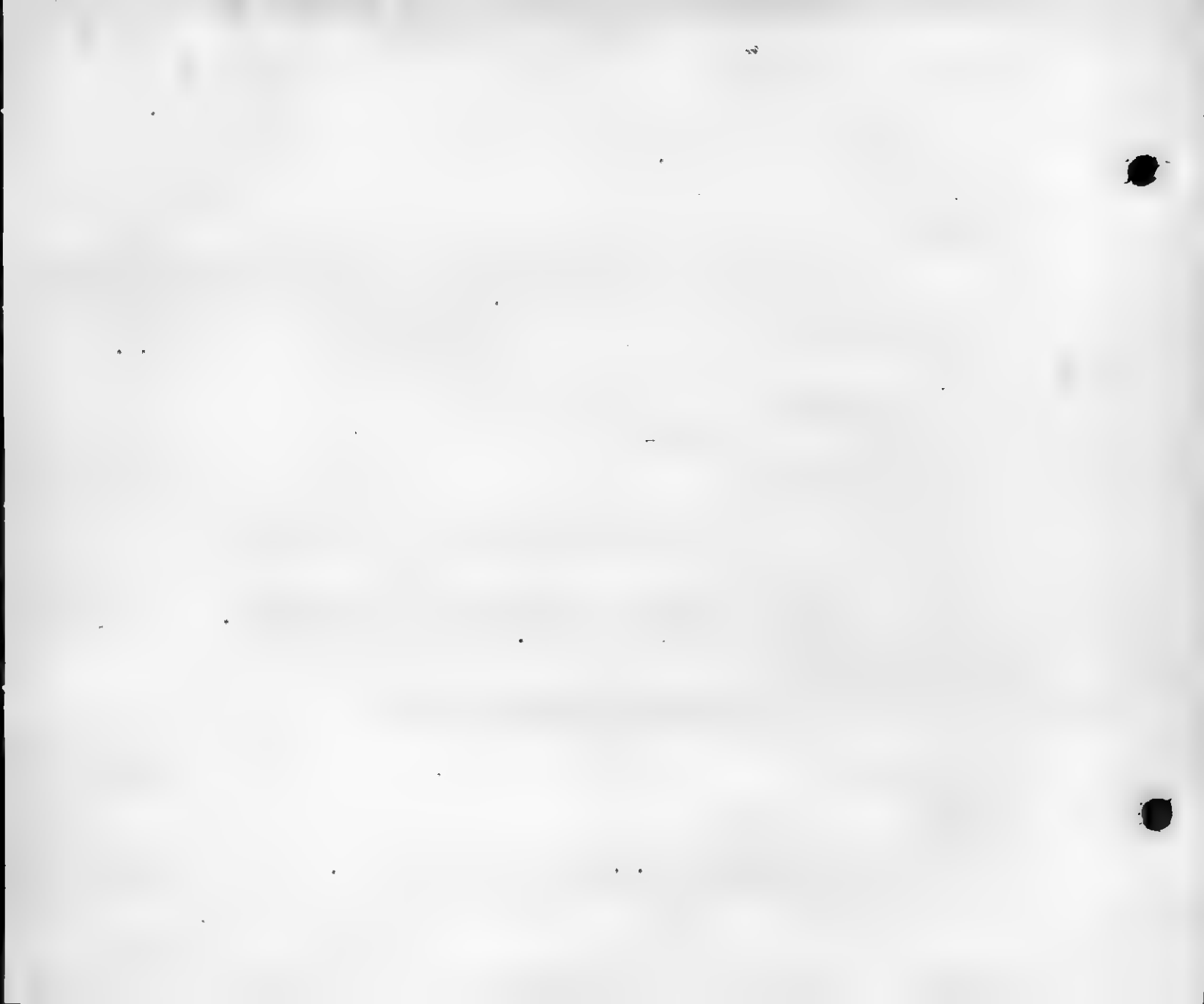
12424

12437

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 22days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
		f. STREET ADDRESS 1008 McAleer Court	
3. NAME OF DECEASED (Type or print) First Leon Middle Joseph Last McComas		4. DATE OF DEATH Month November Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon Joseph McComas		14. MOTHER'S MAIDEN NAME Catherine Dewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-5359	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Septicemia caused by infected gangrenous feet DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome associated with drug or poison intoxication. Steroid medication & periarteritis nodosa.			INTERVAL BETWEEN ONSET AND DEATH Days Months
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 27, 1958 , to November 19, 1959 , that I last saw the deceased alive on November 19, 1959 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) DATE SIGNED 11/20/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-24-59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
24b. REGISTRAR'S SIGNATURE Christ L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12438

CERTIFICATE OF DEATH

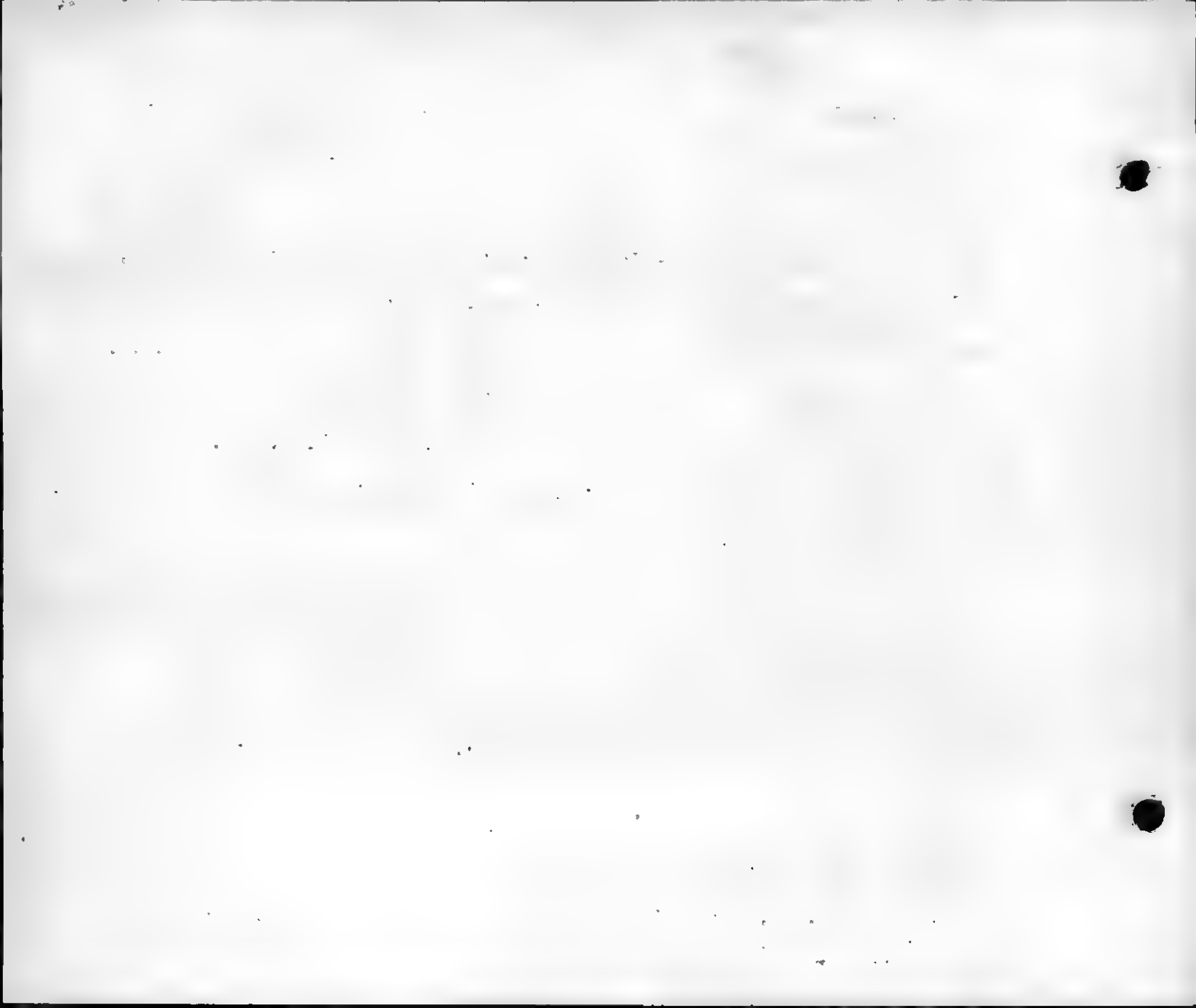
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luther Middle David Last Mehring				4. DATE OF DEATH Month November Day 10 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1887		9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Luther W. Mehring				14. MOTHER'S MAIDEN NAME Leah Reindollar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Dr. Percy Mehring, Phila., Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 6, 1959 to 11-10-1959 , that I last saw the deceased alive on 11-11-1959 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Bridge Md DATE SIGNED 11-12-59							
ACTUAL SIGNATURE J. N. Legg M.D.				DATE SIGNED 11-12-59			
PHYSICIAN'S NAME (Type) T. H. LEGG							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son ADDRESS Taneytown, Maryland				24a. REC'D BY REGISTRAR DATE NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



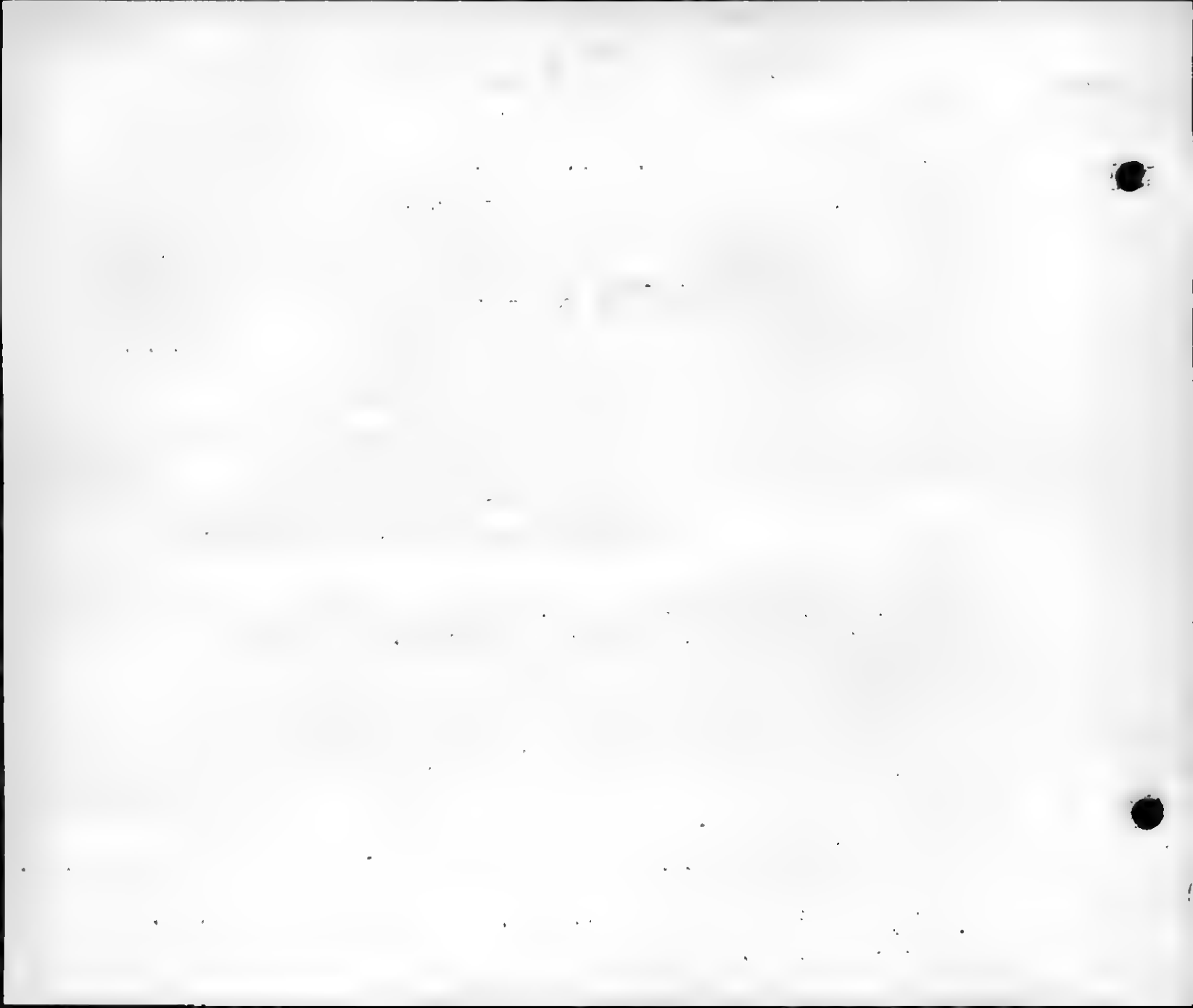
12439

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yr. 8 mo. 27 day.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Melvin		4. DATE OF DEATH Month Day Year November 22, 19 59		5. SEX Female		6. COLOR OR RACE White		7. MARITAL STATUS Widowed		8. DATE OF BIRTH 5-12-81		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Hawes		14. MOTHER'S MAIDEN NAME Sarah Muse		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		INFORMANT Springfield State Hospital Records		Address		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease (decompensated) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Circulatory Disturbance, with Cerebral Arteriosclerosis, with Psychotic Reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town)		20e. (County)		20f. (State)		21. I certify that I attended the deceased from February 6, 1955 to November 22, 1959 , that I last saw the deceased alive on November 22, 1959 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Joseph Flores		M.D.		ADDRESS (Street, city or town, state) November 22, 1959		DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Suckner & Sons - Balti		ADDRESS 17 Md		24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE William J. Suckner		25. NAME OF REGISTRAR William J. Suckner		26. ADDRESS OF REGISTRAR 17 Md		27. CITY OR TOWN Woodlawn, Md.	

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

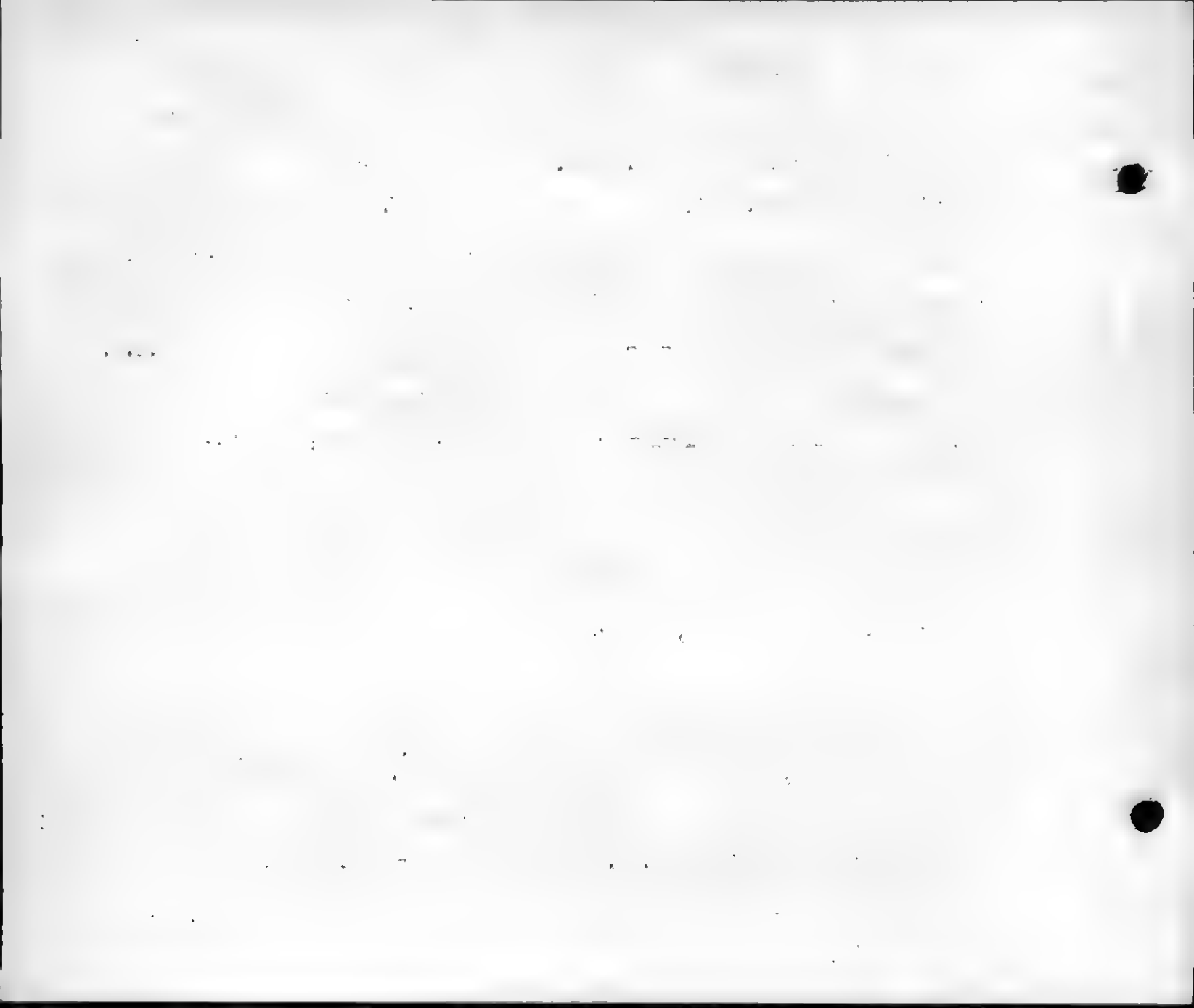


VS A15 (4)
ISM 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12427	
Item 18 Film 252 11-23-59 ams											
12440											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1 PLACE OF DEATH a. COUNTY Carroll MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Frederick						
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)					c LENGTH OF STAY IN 1b 11 m. 27 d.					c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS 227 W. Fifth Street					e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Della Middle Henrietta Last Miss.					4. DATE OF DEATH Month November Day 16, Year 19 59						
5. SEX Female		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 25, 1898		9 AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months 61 Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Whipp					14. MOTHER'S MAIDEN NAME Annie Howard						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16 SOCIAL SECURITY NO. 219-20-0518		INFORMANT Springfield State Hospital Record		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Rupture of left ventricle myocardium Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (c) Coronary arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 15 minutes Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type Organic psychosis?										19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 12, 1958 , to November 16, 1959 , that I last saw the deceased alive on November 16, 1959 , and that death occurred at 8:10 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Konstantin Weber					ADDRESS (Street, city or town, state) Oak Street					DATE SIGNED 11/16/59	
PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.					Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-18-1959		22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery			22d. LOCATION (City, town, or county) (State) Frederick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr.					ADDRESS Frederick, Md.		Ma. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

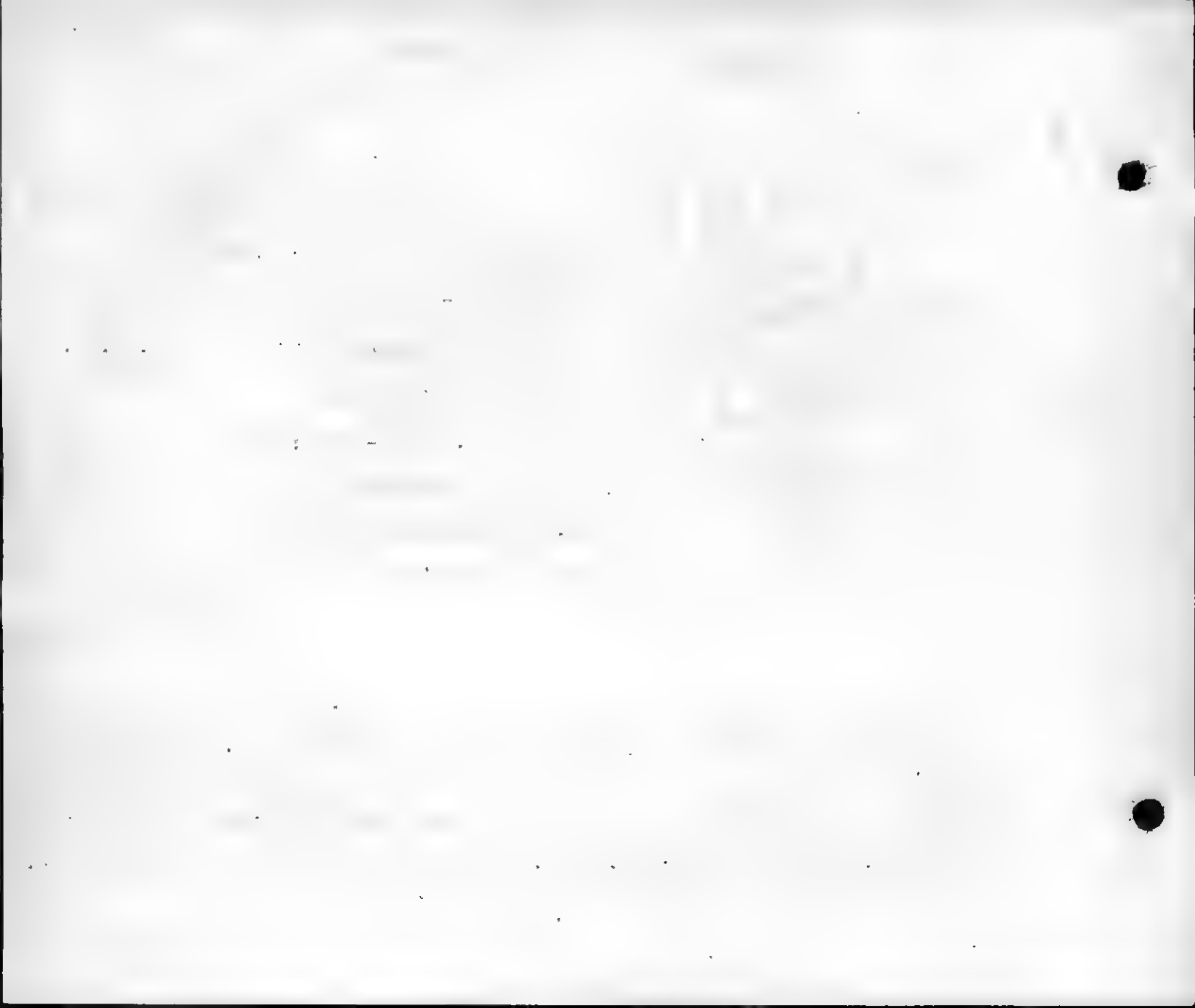
12428

12441

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 98 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
f. STREET ADDRESS 666 Sarah Ann Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Macie Middle Bernice Last Moon		4. DATE OF BIRTH Month November Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1932
9. AGE (In years last birthday) 26 yrs		10. IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Okay Moon		14. MOTHER'S MAIDEN NAME Emma Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-28-6214	
17. ADDRESS Macie B. Moon - Patient		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Insufficiency DUE TO (b) Far Advanced Bilateral Cavitory DUE TO (c) Pulmonary Tuberculosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 19 59 to November 13, 19 59 that I last saw the deceased alive on November 13, 19 59 , and that death occurred at 8:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Maculans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 11-13-59	
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11.19.59		22b. DATE THEREOF 11.19.59	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REG. BY REGISTRAR NOV 23 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
12442					12429				
CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville					c. LENGTH OF STAY IN 1b 2yrs. 9mos. 24days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS 6301 Clearspring Road				
3. NAME OF DECEASED (Type or print) First HERMAN Middle RUNGE Last RUNGE					4. DATE OF DEATH Month November Day 19 Year 1959				
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 23, 1875		9. AGE (In years last birthday) yrs 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alfred Runge					14. MOTHER'S MAIDEN NAME Beatha (last name unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. ---		INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction									INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County) (State)	
21. I certify that I attended the deceased from January 25, 1957 to November 19, 1959 , that I last saw the deceased alive on November 19, 1959 , and that death occurred at 2:45 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Agustin del Campo M.D.					ADDRESS (Street, city or town, state) Springfield State Hospital				
DATE SIGNED 11-19-59									
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.					Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cent.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran					ADDRESS 3000 E. Baltimore Street		24a. REC'D BY REGISTRAR NOV 24 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hines

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12443

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle James Last Ryan		4. DATE OF DEATH Month November Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1867
9. AGE (In years last birthday) yrs. 92		10. UNDER 1 YEAR Months 9 Days 2 Hours 0 Min. 0	11. UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) String conductor		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Ryan		14. MOTHER'S MAIDEN NAME - Braden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 1120.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Years Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2, 1959 to November 3, 1959 , that I last saw the deceased alive on November 2, 1959 , and that death occurred at 5:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/3/59			
ACTUAL SIGNATURE Agustin del Campo M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. SURVIVAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-6-59	
22c. NAME OF CEMETERY OR CREMATORY Barbours		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Kuck ADDRESS 5305 Harford Rd		24a. REC'D BY REGISTRAR DATE NOV 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12444

CERTIFICATE OF DEATH

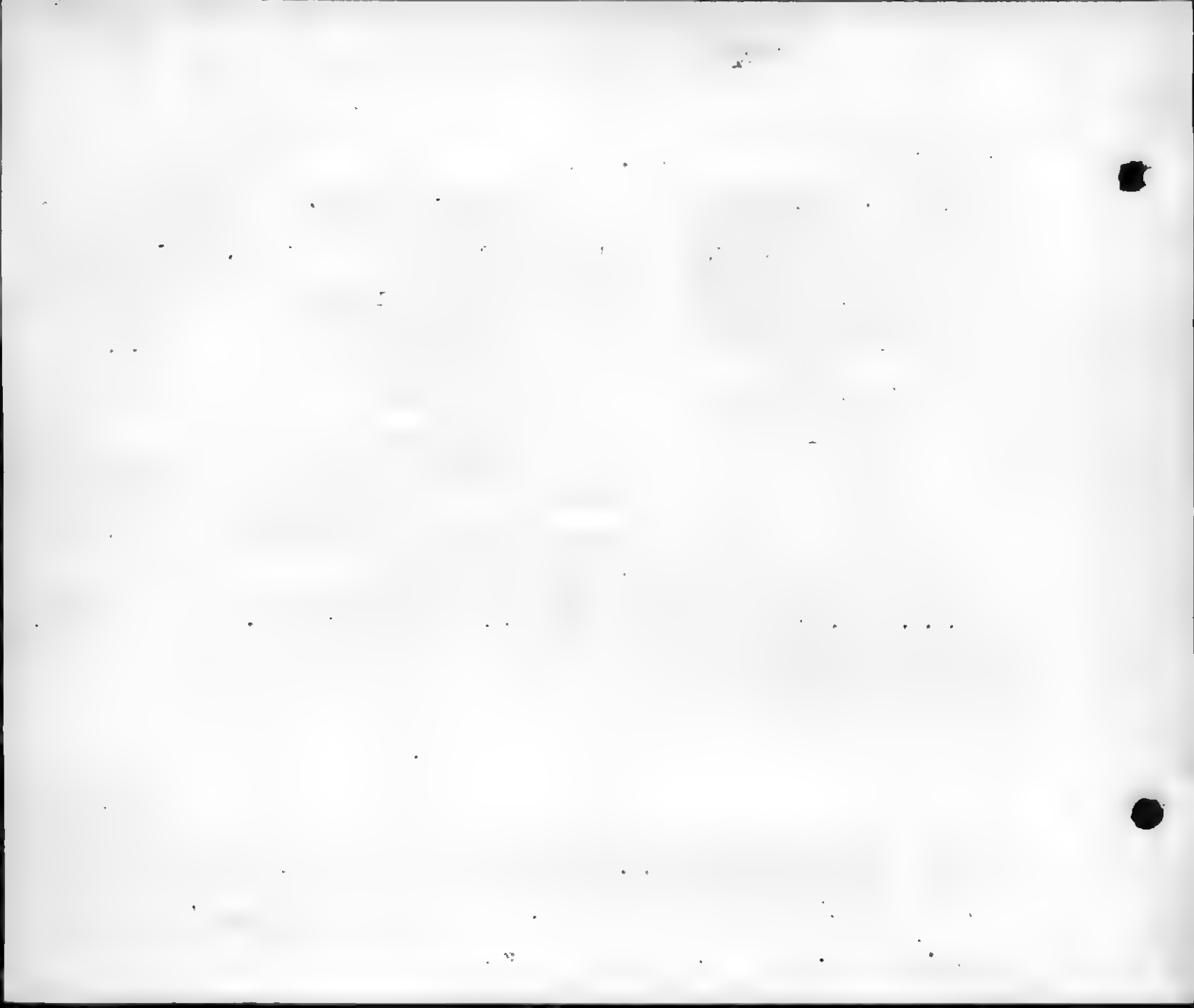
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mos. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3803 Ednor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Katherine		Middle O'Connor		Last Rytina			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 24, 1880			
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Roger O'Connor				14. MOTHER'S MAIDEN NAME Ann Flynn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -		INFORMANT Springfield Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 14, 1959 , to November 12, 1959 , that I last saw the deceased alive on November 11, 1959 , and that death occurred at 5:35 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/12/59 ACTUAL SIGNATURE Agustini del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
BURIAL		11/16/59		CATHEDRAL		FREDERICK RD MD			
23. FUNERAL DIRECTOR'S SIGNATURE Hubel Bros				ADDRESS 7110 BELAIR RD		24e. REC'D BY REGISTRAR DATE NOV 16 '59			
						24b. REGISTRAR'S SIGNATURE C. J. H. & Co.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours *after* death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

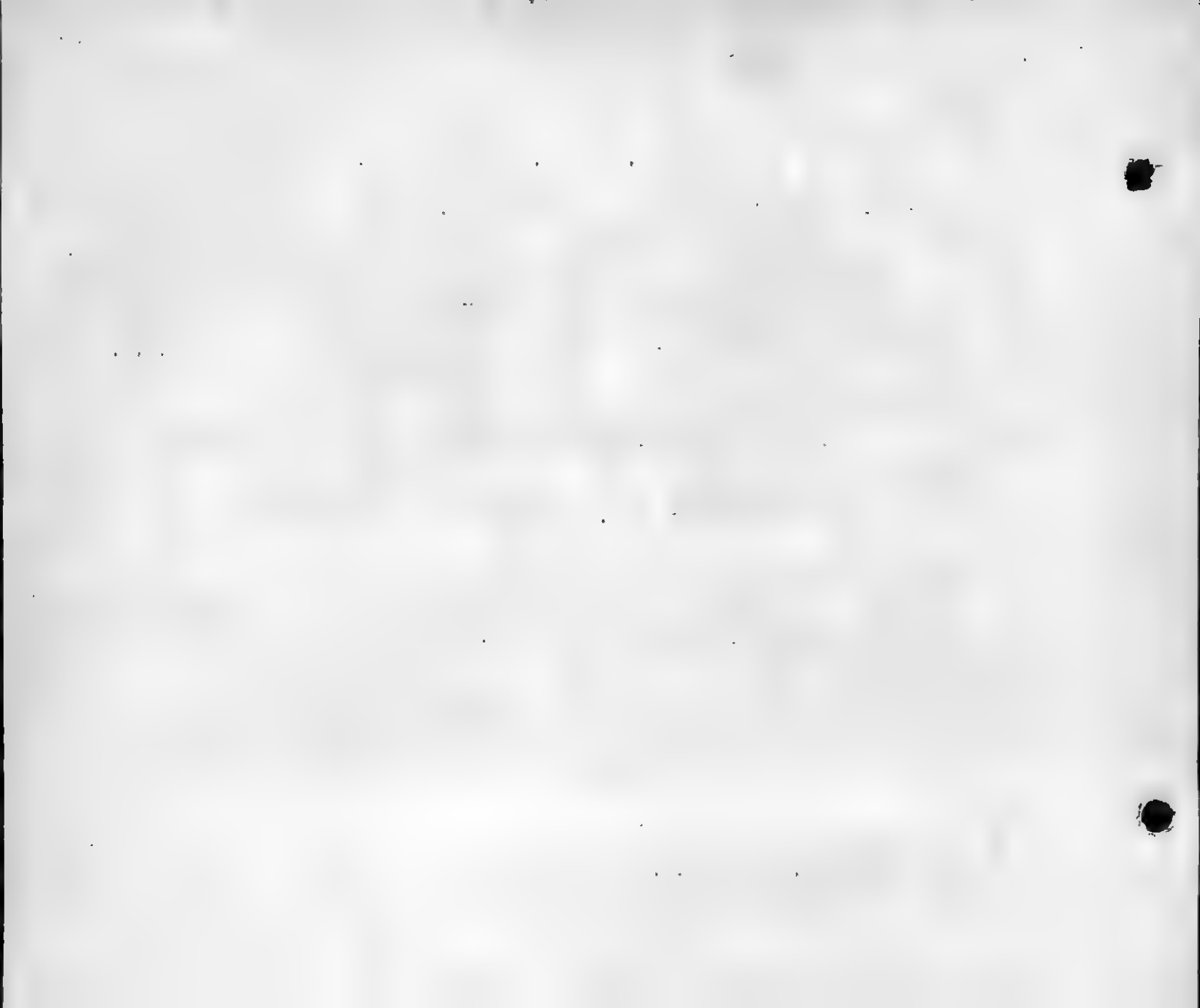
VS A15 (4)
LS 15 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12432
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12445
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 5 mos. 17 das. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2, Maryland d. STREET ADDRESS 24 E. Preston Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Evelyn Middle Blanche Last Schreck					4. DATE OF DEATH Month November Day 24, Year 19 59					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-28-22		9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Schreck					14. MOTHER'S MAIDEN NAME Agnes Miller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-18-3123		17. INFORMANT Address Springfield State Hospital Records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the trachea by a piece of meat. 721.7 Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ Schizophrenic Reaction, Paranoid Type 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH seconds
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated meat							
20c. TIME OF INJURY Month, Day, Year 11-24-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Sykesville (County) Carroll (State) Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 11-24-59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/59		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) Parkville, Md. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home 4210 Belair Road.						24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE C. L. L. L.		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12446

CERTIFICATE OF DEATH

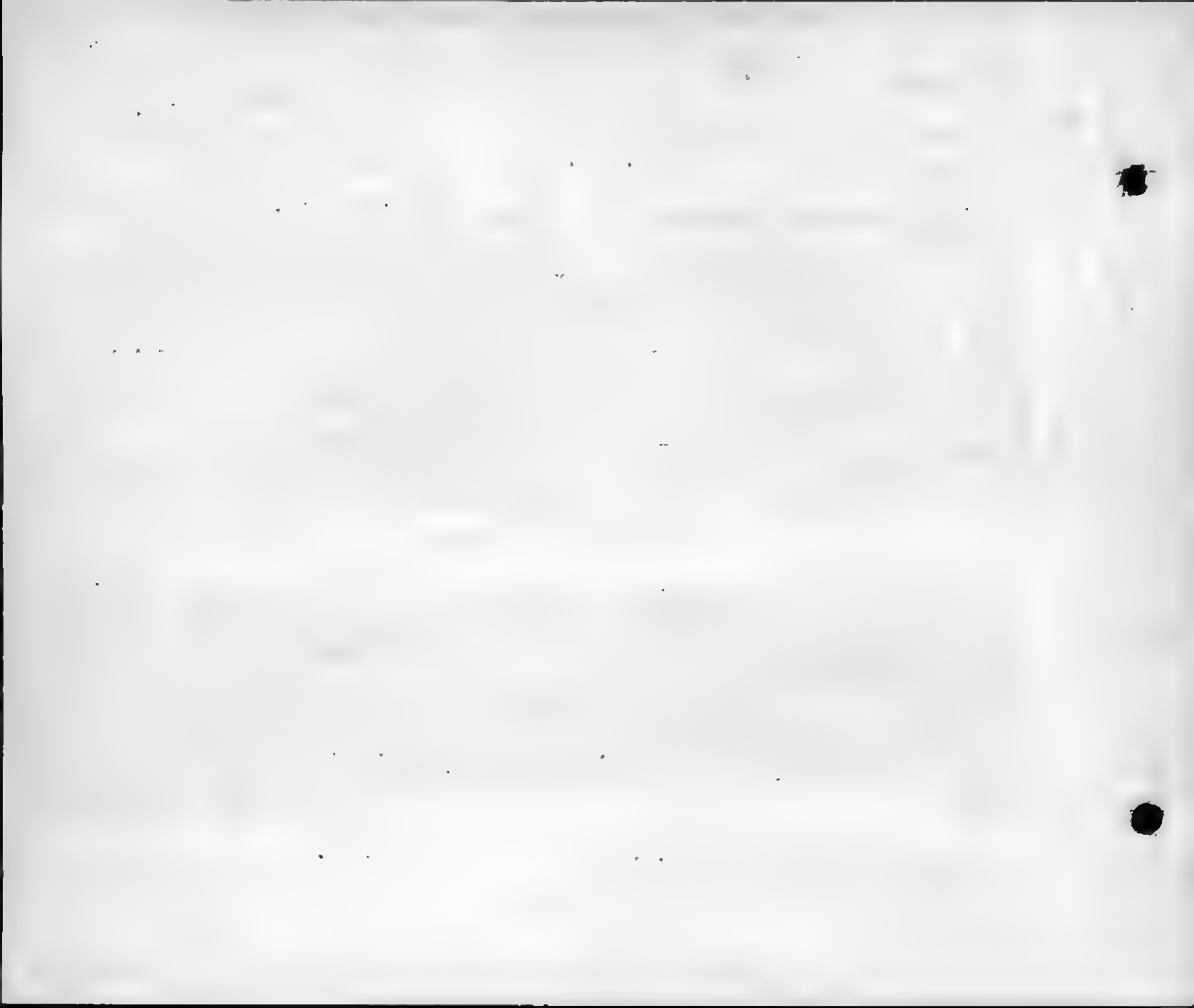
Reg. Dist. No.

12433

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 30yrs. 8mos. 20days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1307 Clarkson St.	
3. NAME OF DECEASED (Type or print) First Mary Middle Schwarz Last Schwarz		4. DATE OF DEATH Month November Day 17, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1882
9. AGE (In years lost birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leopold Schwarz		14. MOTHER'S MAIDEN NAME Carrie Schaubman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Congestive heart failure (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Epilepsy with mental deficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Days Weeks Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11, 1958 to Nov. 17, 1959 , that I last saw the deceased alive on November 17, 1959 , and that death occurred at 9:20A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Francesco Magro M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) Francesco Magro, M.D.		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/59	
22c. NAME OF CEMETERY OR CREMATORY Landon Park		22d. LOCATION (City, town, or county) (State) Frederick Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Krause Funeral Home		ADDRESS 1216 S Charles St	
24a. REC'D BY REGISTRAR NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

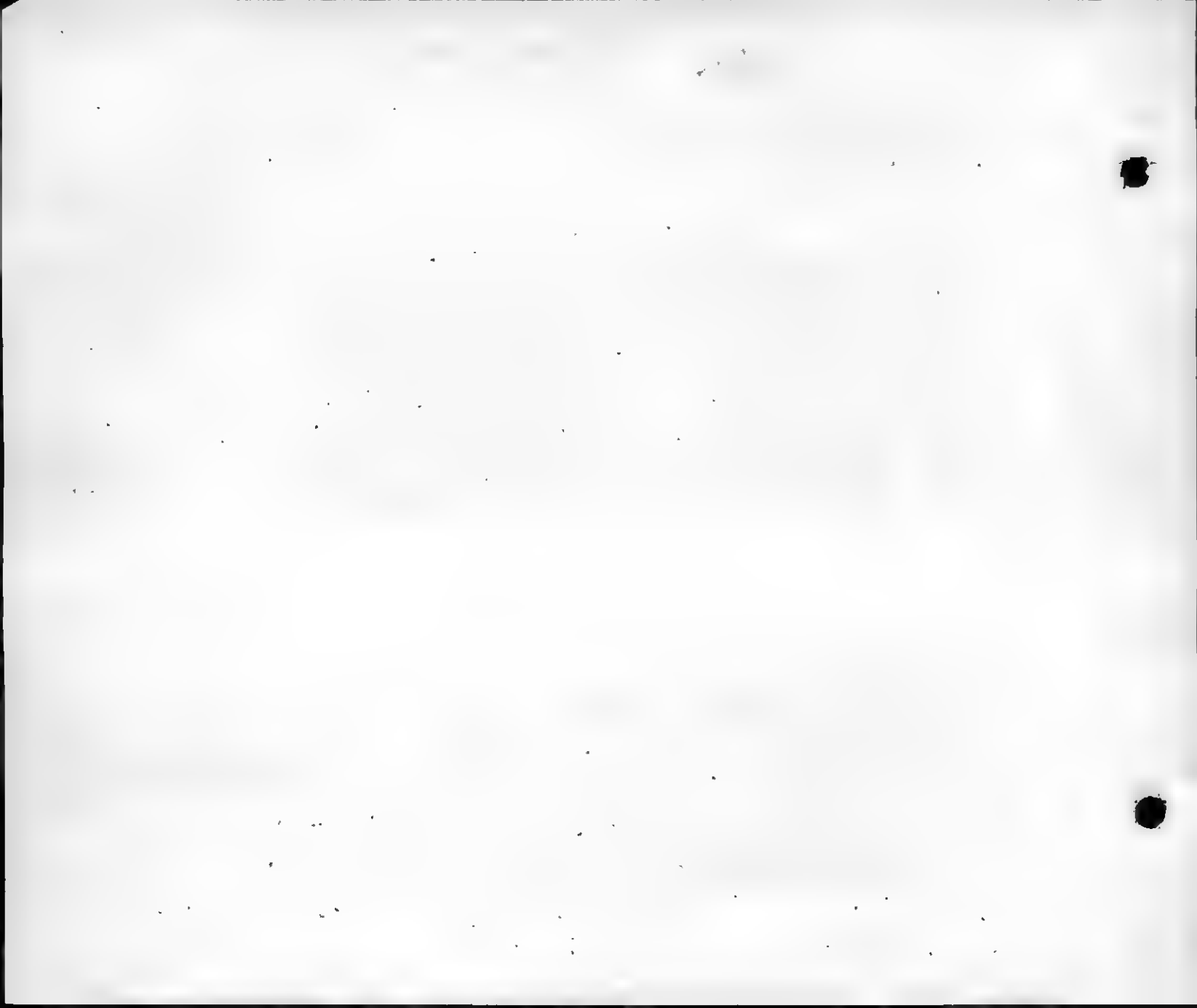
Reg. Dist. No.

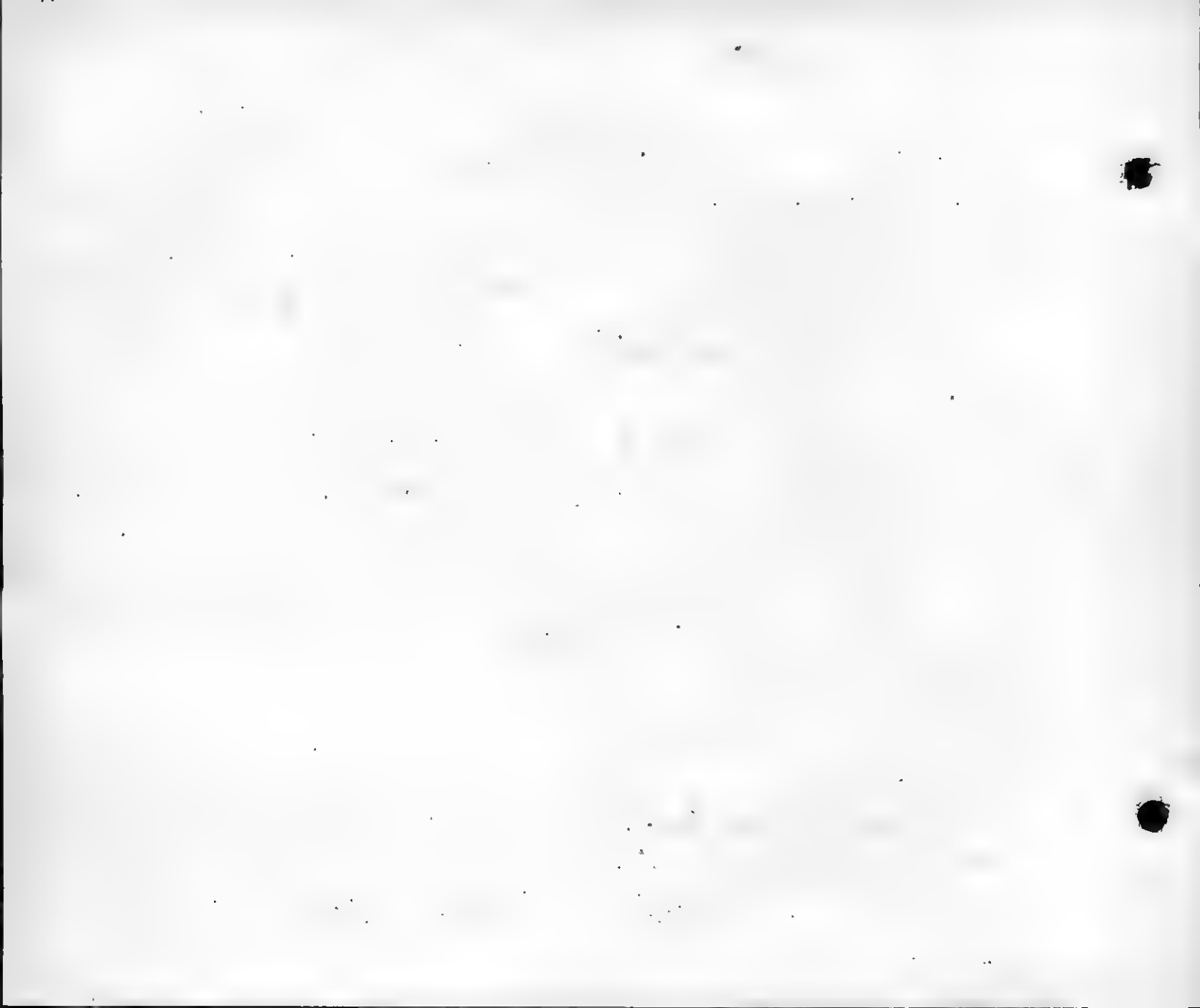
12447

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snyderburg</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snyderburg</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS - I - SIMMONS</u>		4. DATE OF DEATH <u>Nov 8 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John N. Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Alice A. Spencer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>M</u>	
17. INFORMANT <u>Mrs. Thomas Simmons, Snyderburg, Md</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Head of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1959</u> , to <u>November 8, 1959</u> , that I last saw the deceased alive on <u>November 8, 1959</u> , and that death occurred at <u>12:45 A.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>11/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Snyderburg</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edee E. Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Tipton</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12449

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY CARRROLL ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN First SMITH Middle SMITH Last				4. DATE OF DEATH 11 Month 28 Day 1959 Year			
5. SEX M		6. COLOR OR RACE WH		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY THINK		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FAR ADVANCED BILATERAL PULMONARY TUBERCULOSIS - ACTIVE. D. SCHIZOPHRENIA COAX							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from SEPT 11-27 , 19 55 to 11-27 , 19 59 that I last saw the deceased alive on 11-27 , 19 59 , and that death occurred at 7:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Julian Radzykenycz M.D.				ADDRESS (Street, city or town, state) Oxfordville, Md. DATE SIGNED 11/28/59			
PHYSICIAN'S NAME (Type) JULIAN RADZYKENYCH MD				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-1-59			
22c. NAME OF CEMETERY OR CREMATORY New Catholic				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Haight ADDRESS Oxfordville, Md.				24a. REC'D BY REGISTRAR DEC 2 '59			
				24b. REGISTRAR'S SIGNATURE Carlton R. K...			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12450

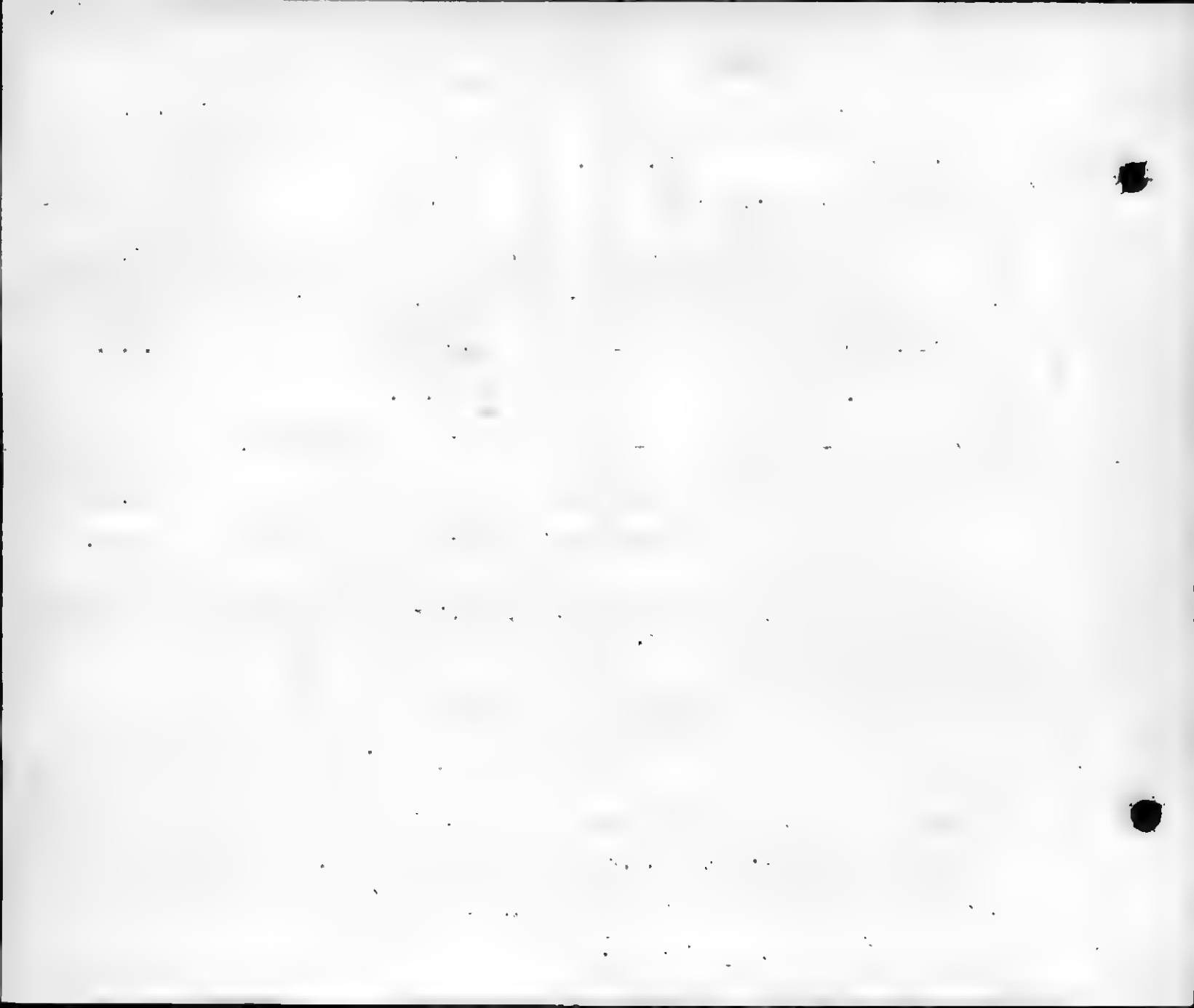
CERTIFICATE OF DEATH

Reg. Dist. No.

12437

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN IB <u>18yrs. 10mos. 2days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Jeanette</u> Last <u>Sowers</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>January 9, 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book-keeper</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Benjamin F. Sowers</u>				14. MOTHER'S MAIDEN NAME <u>Ida E. F. Bachtel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>		INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Schizophrenic reaction, hebephrenic type. Fracture, left tibia and fibula.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED?</u> <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/7/55</u> , 19 <u> </u> , to <u>Nov. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>November 21</u> , 19 <u>59</u> , and that death occurred at <u>6:20A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				DATE SIGNED <u>11/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/24/59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Baltimore Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell Pileonville S. Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
c. LENGTH OF STAY IN 1b 8 months		d. STREET ADDRESS 1666 Northbourne Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Pearce Last Stafford		4. DATE OF DEATH Month November Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880 February 6, 1901
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months 11 Days 18 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Pearce		14. MOTHER'S MAIDEN NAME Mary Mossholder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-03-3102	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Days Years Years.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1959 , to November 24, 1959 , that I last saw the deceased alive on November 24, 1959 , and that death occurred at 11:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 11/24/59			
ACTUAL SIGNATURE Francesco Magro M.D.		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Francesco Magro, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Charles L. Howard	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
ISM 9/58

I have been thinking of you very much lately
and wondering how you are getting on.

CERTIFICATE OF DEATH

Reg. Dist. No.

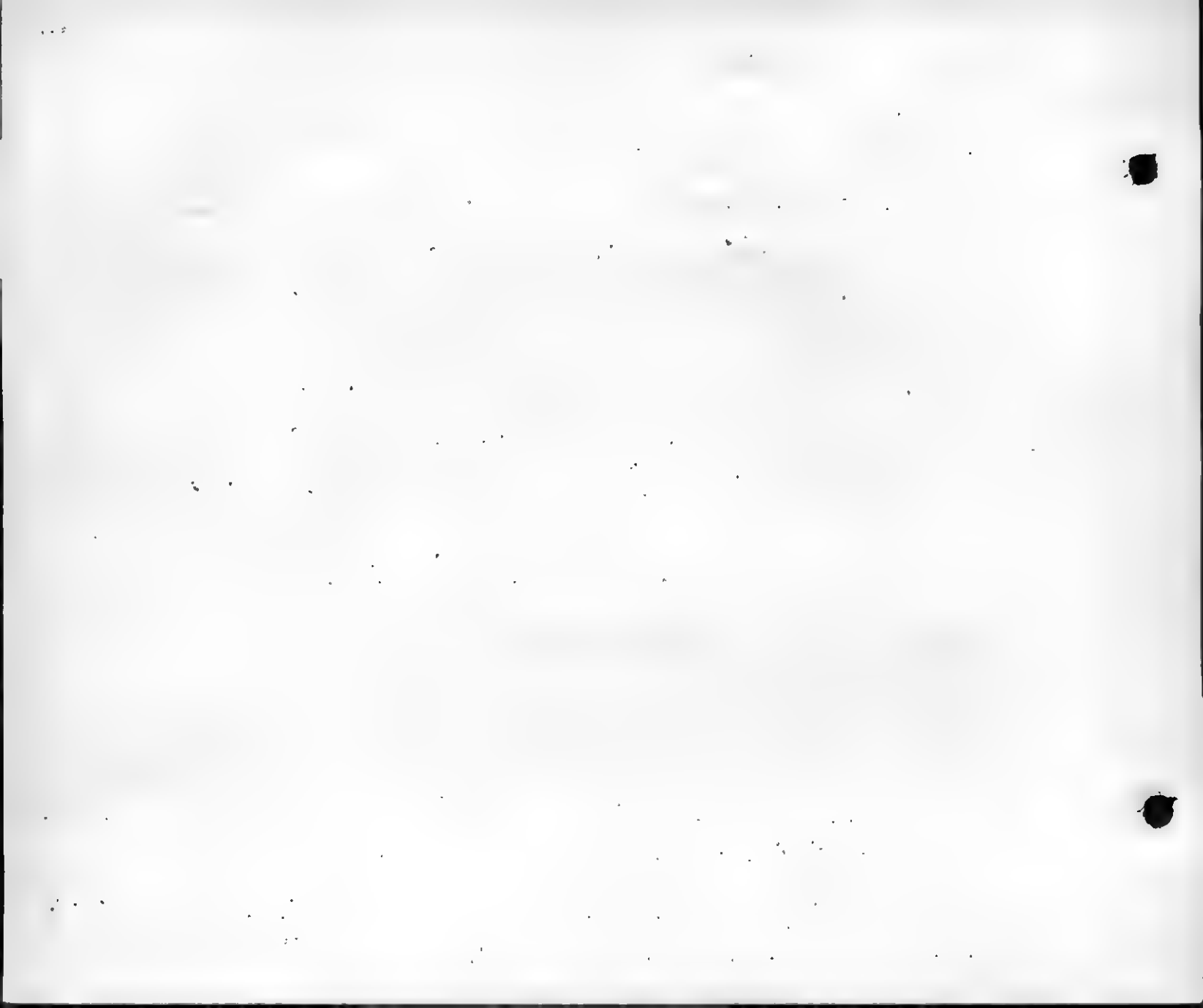
12439

12452

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN lb 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peterson Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amanda Middle L. Last Stahley		4. DATE OF DEATH Month November Day 27 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	11. IF UNDER 24 HRS Months 86 Days 86 Hours 86 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joel Bollinger		14. MOTHER'S MAIDEN NAME Mary Bollinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. James P. Stahley		Address Taneytown, Md. RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Permanently Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs. INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/11 , 19 44 to 11/27 , 19 59 , that I last saw the deceased alive on 11/20 , 19 59 , and that death occurred at 2 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. S. McVaugh M.D.		ADDRESS (Street, city or town, state) Taneytown, Md. DATE SIGNED 11/27/59	
PHYSICIAN'S NAME (Type) R. S. McVaugh			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Reformed Church		22d. LOCATION (City, town, or county) (State) Taneytown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Luss		24a. REC'D BY REGISTRAR DEC 1 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF DEATH

Reg. Dist. No.

12440

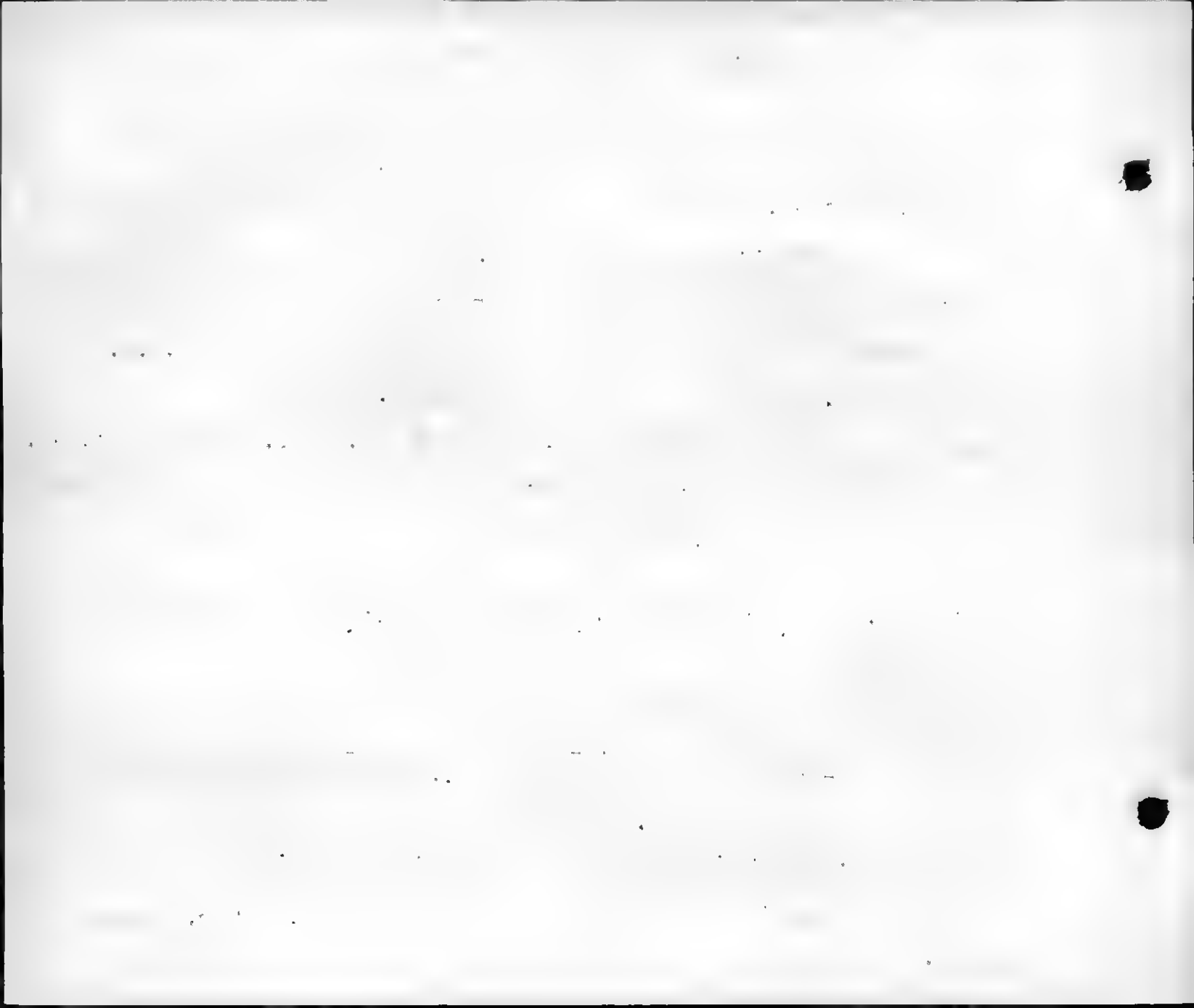
12453

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr 11m 15d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield St. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 722 Northern Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Last Taylor		4. DATE OF DEATH Month 11 Day 15 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-81
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Taylor		14. MOTHER'S MAIDEN NAME Isabella Ann Sisco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Springfield St. Hosp. Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 521X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Abscess DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS ass. with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction			INTERVAL BETWEEN ONSET AND DEATH one week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-27 , 19 57 , to 11-15 , 19 59 , that I last saw the deceased alive on 11-15 , 19 59 , and that death occurred at 8:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. Joseph Flores M.D.		November 15, 1959	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/59	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John O. Mitchell & Sons, Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE NOV 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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12454

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admision) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville	
3. NAME OF DECEASED (Type or print) First Middle Last Jackson Thomas		4. DATE OF DEATH Month Day Year November 13 19 59	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1916
9. AGE (In years less birthday) yrs 43		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Remington, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Thomas		14. MOTHER'S MAIDEN NAME Mary Sayles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. INFORMANT Address Jackson Thomas - Patient	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Sufficiency 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver & Pulmonary tbc. with Pleurisy (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 30 19 59 to November 13 19 59 that I last saw the deceased alive on November 13 19 59 and that death occurred at 6:15 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Maculans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 11-13-59	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, Supt.		Henryton State Hospital, Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/59	22c. NAME OF CEMETERY OR CREMATORY St. James Baptist	22d. LOCATION (City, town, or county) (State) Bealeton, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shover		24a. RECEIVED BY REGISTRAR NOV 18 1959	24b. REGISTRAR'S SIGNATURE Arthur L. Knecht

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CERTIFICATE OF DEATH

Reg. Dist. No.

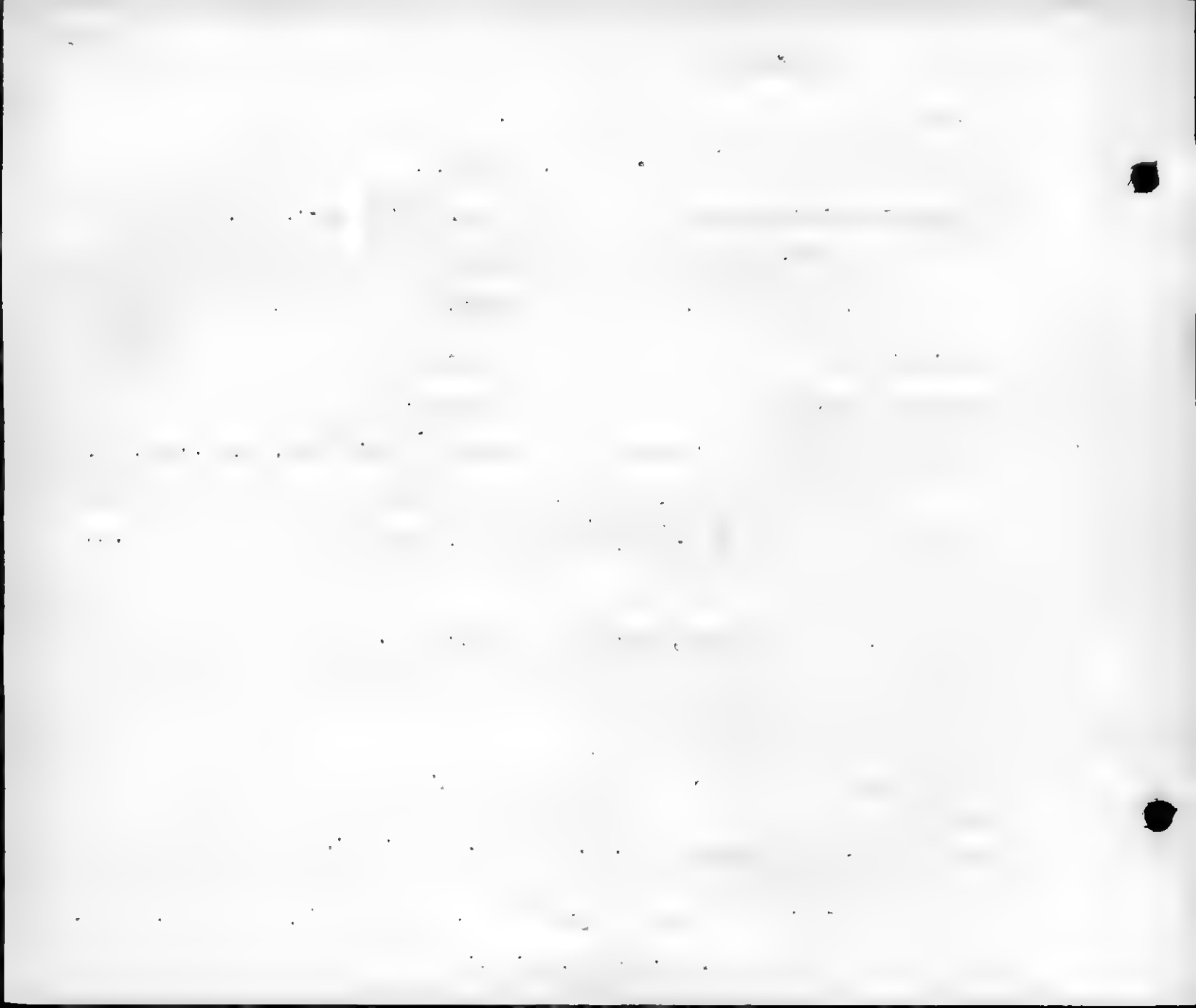
12442

12455

1. PLACE OF DEATH a. COUNTY Carroll County		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md b. COUNTY St	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1 year 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael Trawinski		4. DATE OF DEATH Month Day Year 11-22-59 19	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-31-70
9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A. Naturalized	
13. FATHER'S NAME George Trawinski		14. MOTHER'S MAIDEN NAME None given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-14-0807	
17. INFORMANT Records		Address Springfield State Hosp. Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary Tuberculosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Heart Disease DUE TO Years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome, associated with senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-21-58 , 19 58 , to 11-22 , 19 59 , that I last saw the deceased alive on 11-21 , 19 59 , and that death occurred at 1:05a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Francesco Magro M.D.			
PHYSICIAN'S NAME (Type) Dr. Francesco Magro			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-1959	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Springfield Hosp. Sykes, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Gvach & Son,		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
ADDRESS 900 N. Chester St. Balto. 5		24b. REGISTRAR'S SIGNATURE Arthur J. Kane	

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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 4252 11-23-59 et

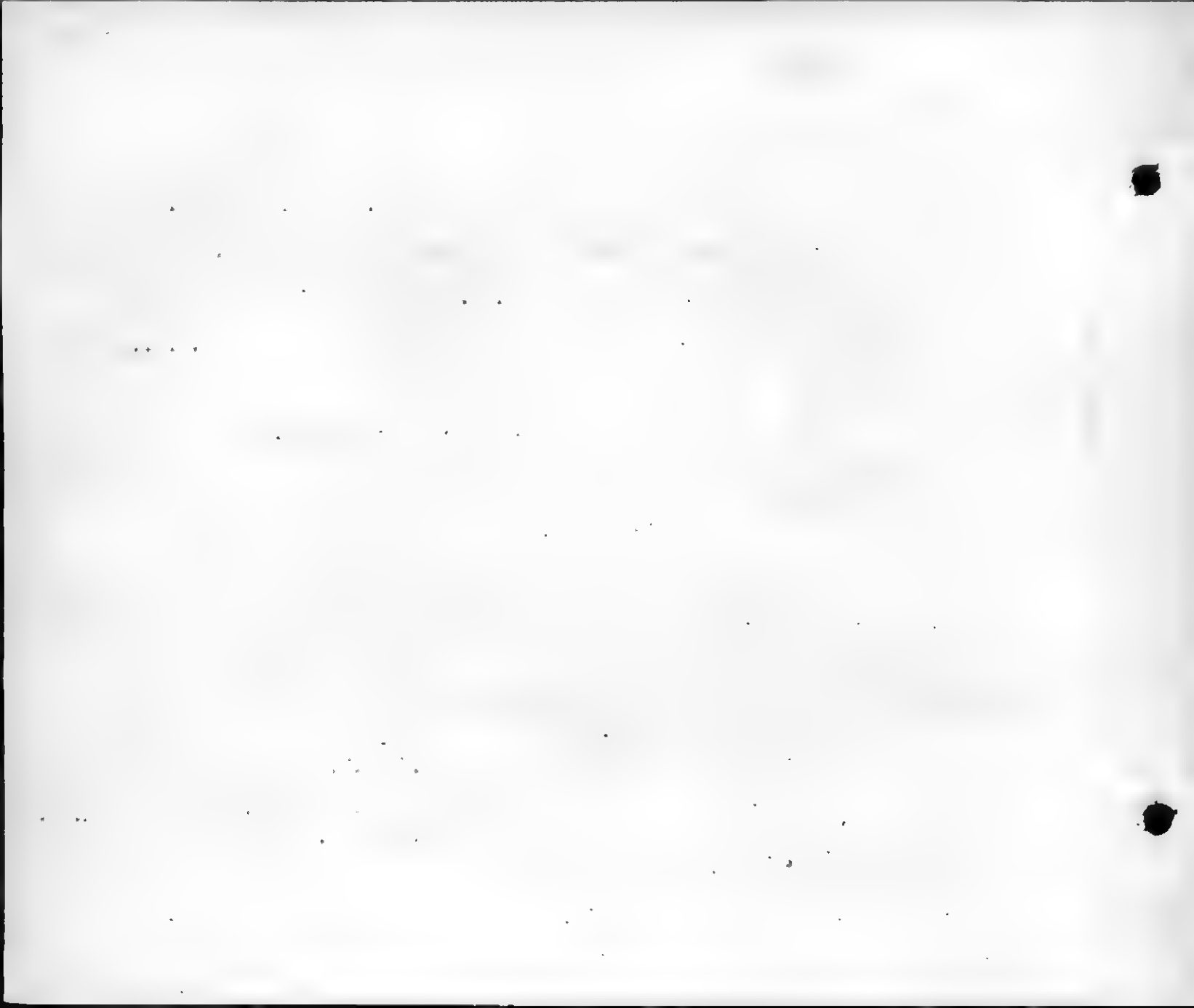
CERTIFICATE OF DEATH

Reg. Dist. No.

12443

12456

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 3Y 10M 1D		d. STREET ADDRESS 5800 Walter Av., Baltimore 6, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Bertha Stann Von Bussenius		4. DATE OF DEATH Nov. 14 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.13.80
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A., naturalized	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Chronic Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13-56 , 19 11-14-59 , that I last saw the deceased alive on 11-13-59 , 19 12.55 A.M. , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11.14.59 M.D. Sykesville, Md.			
ACTUAL SIGNATURE Joseph Flores		PHYSICIAN'S NAME (Type) Joseph Flores	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorah Funeral Home		ADDRESS 744 Belair Rd	
24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	



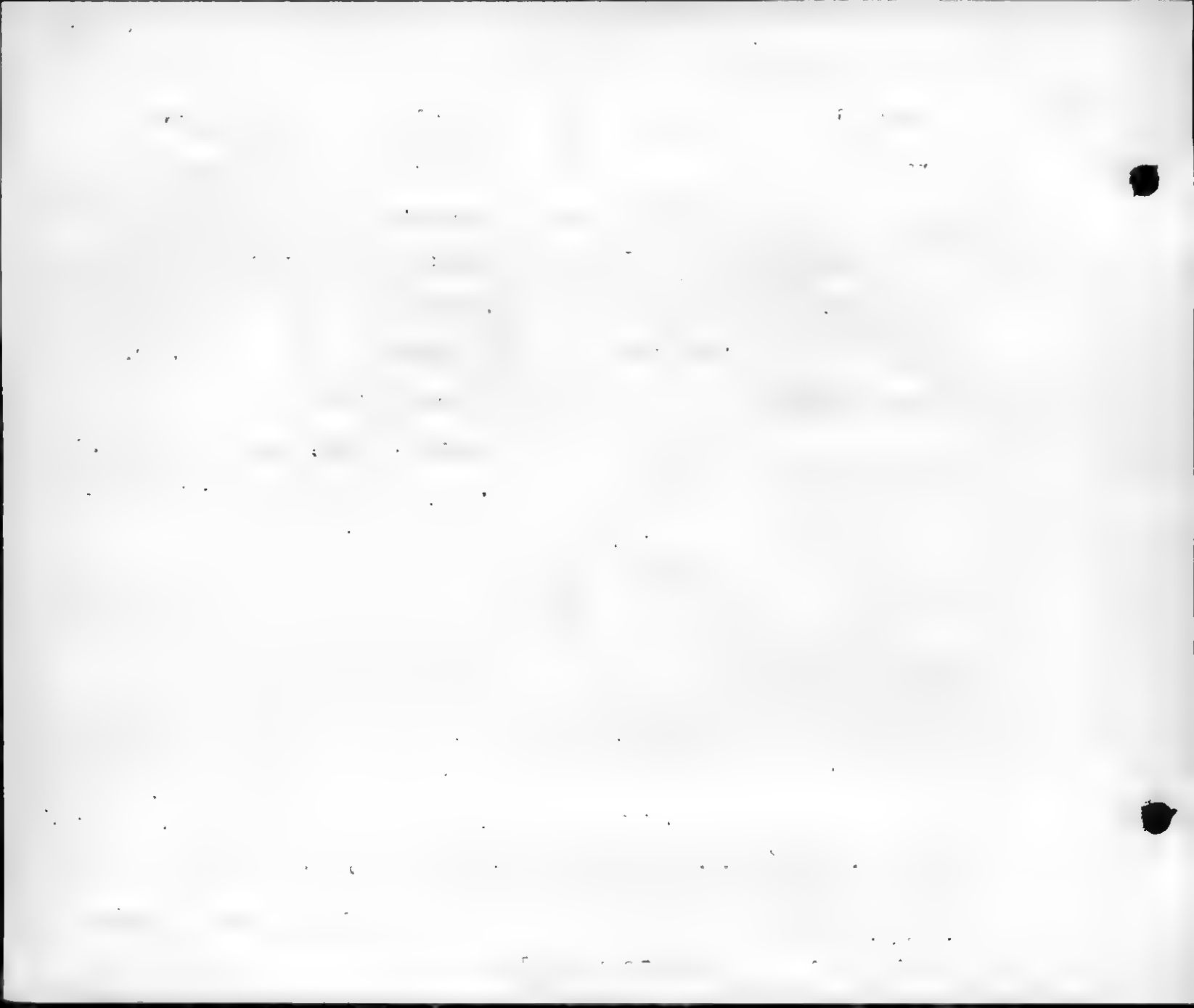
12457

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS E. Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Jane Wantz				4. DATE OF DEATH Month Day Year November 13, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1886	
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Carbaugh				14. MOTHER'S MAIDEN NAME Hannah Wantz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Disease (c) Nervous Shock				INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Union Bridge, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from June 7, 1958 to Nov 8, 1959 , that I last saw the deceased alive on Nov 8, 1959 , and that death occurred at 9 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE T. H. Legg, M.D.				ADDRESS (Street, city or town, state) Union Bridge, Md.			
PHYSICIAN'S NAME (Type) T.H. Legg, M.D.				DATE SIGNED 11-15-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORY Baust Cemetery		22d. LOCATION (City, town, or county) (State) Tyrone, Carroll, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son				ADDRESS Taneytown, Maryland			
24a. REC'D BY REGISTRAR DATE NOV 18 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

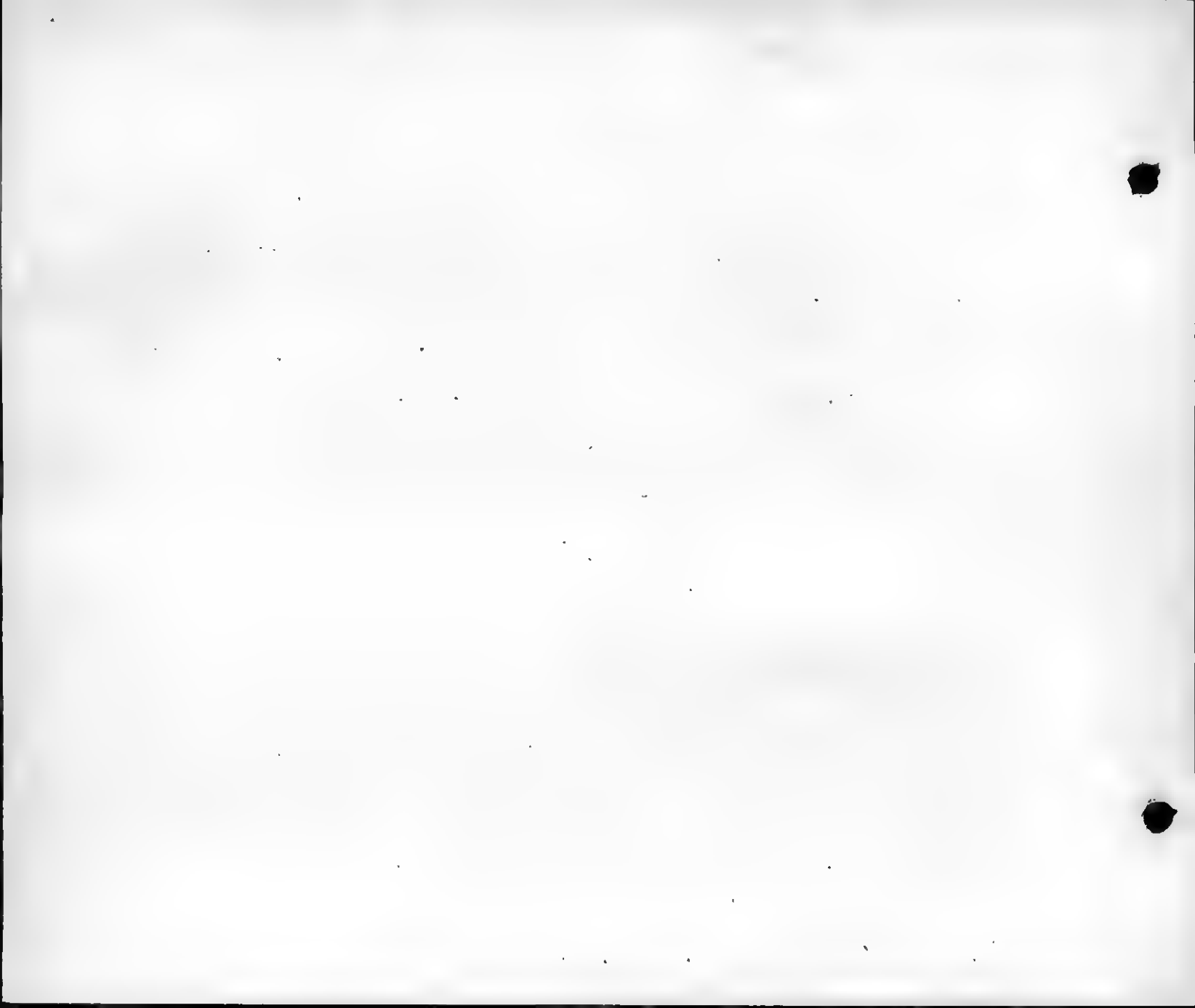
CERTIFICATE OF DEATH

12445

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>V</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>			c. LENGTH OF STAY IN 1b <u>369</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				d. STREET ADDRESS <u>(10 Jasper Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u></u> Last <u>Waters</u>				4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1924</u>	
9. AGE (In years last birthday) <u>35</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Waters</u>				14. MOTHER'S MAIDEN NAME <u>Ella Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-1-1403</u>		INFORMANT <u>Dorothy Water - Patient</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>far advanced bilateral a vitary a onary</u> <u>002 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis, right thoraco lary, right lobe resection</u> (c) <u>Cardiovascular Insufficiency</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 29, 1958</u> , to <u>November 1, 1959</u> , that I last saw the deceased alive on <u>November 1, 1959</u> , and that death occurred at <u>5:30 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edgars M. Maculans</u> M.D.				ADDRESS (Street, city or town, state) <u>Henryton State Hospital</u>		DATE SIGNED <u>11-1-</u>	
PHYSICIAN'S NAME (Type) <u>Edgars M. Maculans, M.D.</u>				<u>Henryton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/4/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Chatman</u>				ADDRESS <u>1704 M. S. Bulch</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capcan papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12459

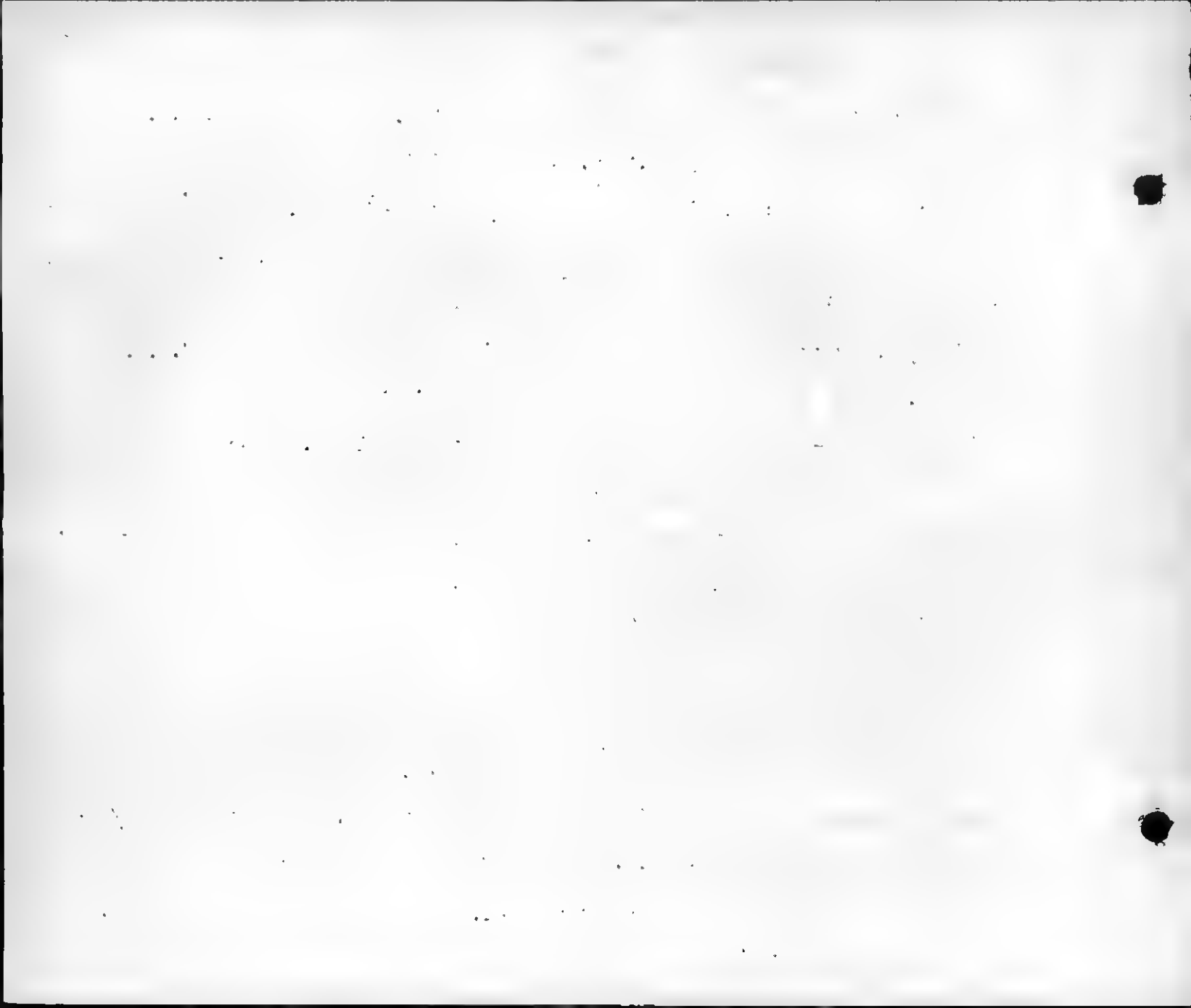
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 25yrs. 8mos. 16days Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3600 Fairview Ave. 1709 Westwood Ave.	
3. NAME OF DECEASED (Type or print) First Mary Middle Theresa Last Weber		4. DATE OF DEATH Month November Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 83 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing plant; housework		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank J. Weber	
14. MOTHER'S MAIDEN NAME Annie Elliott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) -	
16. SOCIAL SECURITY NO. -		INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH Days Two weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dementia praecox (schizophrenia)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955 to November 23, 1959 that I last saw the deceased alive on November 22, 1959 , and that death occurred at 1:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 11/23/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/25/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Lieberman		24a. REC'D BY REGISTRAR DATE NOV 24 '59	24b. REGISTRAR'S SIGNATURE William S. Hume

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12460

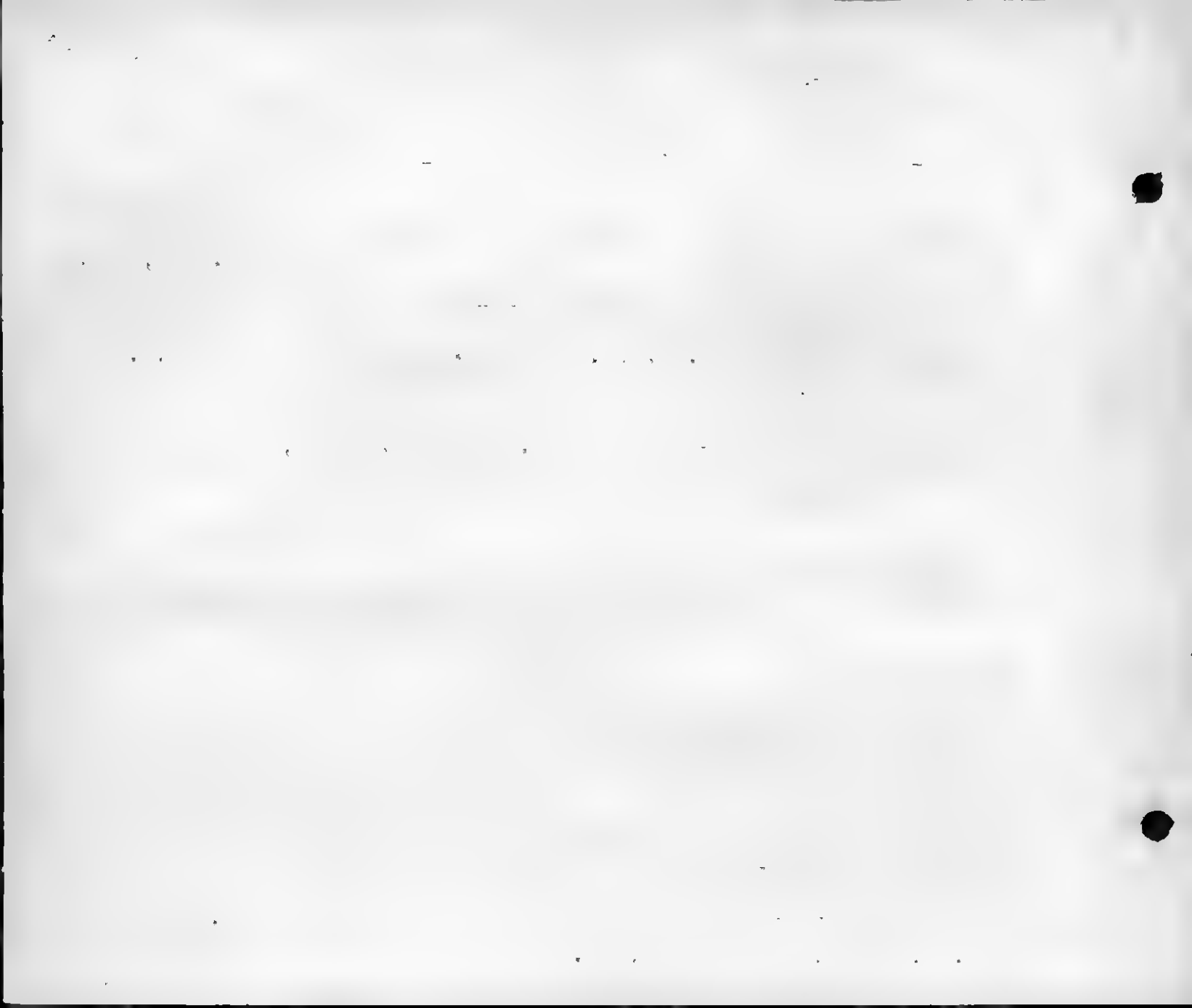
CERTIFICATE OF DEATH

12447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Woodbine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Woodbine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WELSH Last		4. DATE OF DEATH Month NOV. Day 12, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1892
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired watchman		10b. KIND OF BUSINESS OR INDUSTRY Md. S.R.C.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nimrod Welsh		14. MOTHER'S MAIDEN NAME Betty ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Martha M. Welsh,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Grand Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 8 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov-2 , 19 59 , to Nov-12 , 19 59 , that I last saw the deceased alive on Nov-12 , 19 59 , and that death occurred at 10:00 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE MORRELL N. MASTIN		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) MORRELL N. MASTIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-15-1959	22c. NAME OF CEMETERY OR CREMATORY Winfield Church of God	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE William S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12448

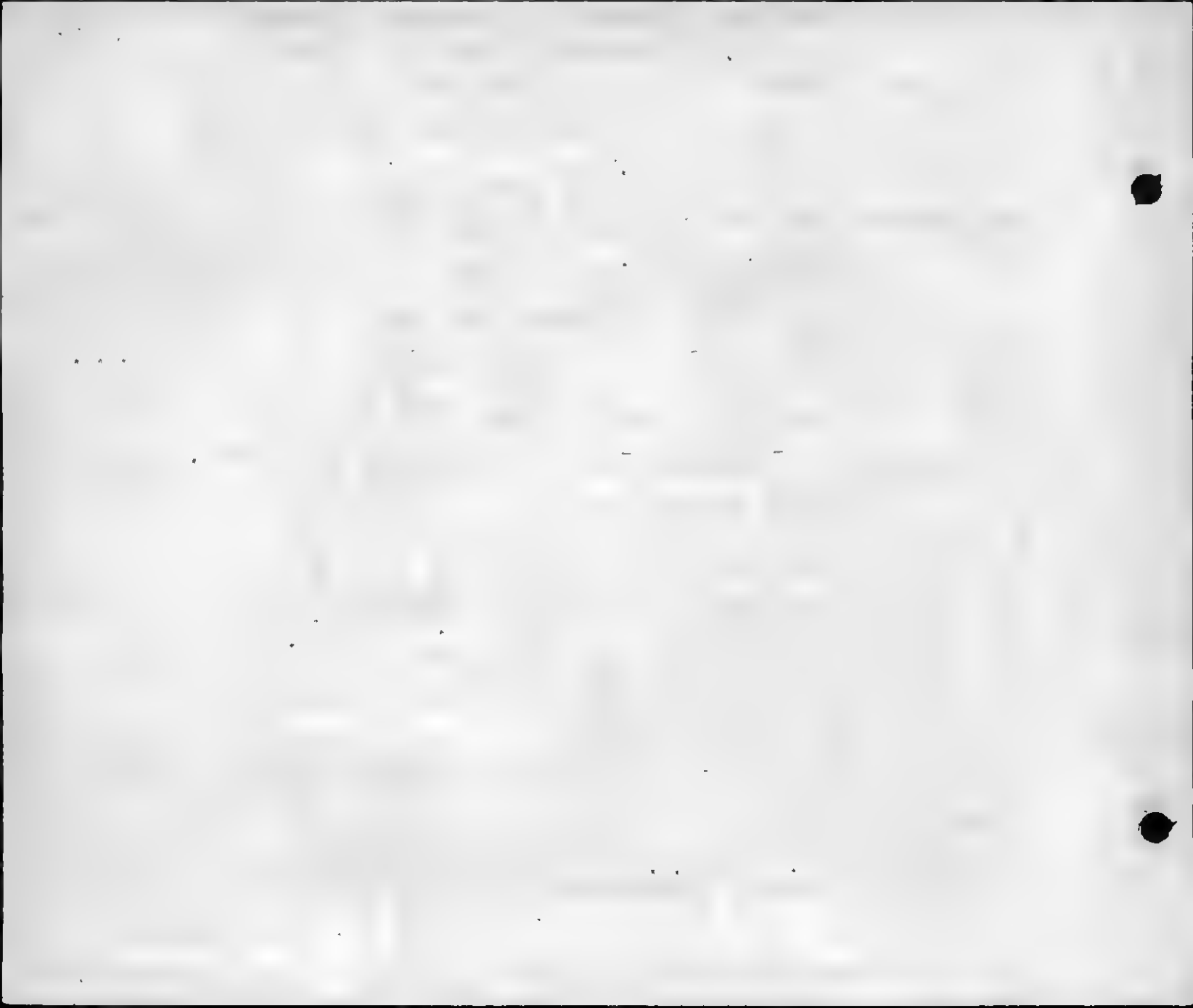
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> 12461 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>16yrs. 10days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. STREET ADDRESS <u>401 Frederick Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>F.</u> Last <u>White</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with syphilitic meningoencephalitis. Fracture, left humerus.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>		DATE SIGNED <u>11/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>Nov 10, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE NOV 13 '59	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12449

12462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mo. - 19 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ida Middle Cohen Last Witkowski		4. DATE OF DEATH Month 11 Day 13 Year 1959		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/93		9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 11 Days 13 Hours 15 Min. 54					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Max Cohen		14. MOTHER'S MAIDEN NAME Fanny Brodsky		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 288-05-7232					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bulbar Balsy 356.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH years years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with senile brain disease??		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 6/25/59 , 19____, to 11/13/59 , 19____, that I last saw the deceased alive on 11/13/59 , 19____, and that death occurred at 8:30p. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Springfield State Hosp. Sykesville, Md.		DATE SIGNED Francesco Magro		ACTUAL SIGNATURE Francesco Magro		PHYSICIAN'S NAME (Type) Francesco Magro, M.D.		SYLVESVILLE, MARYLAND		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 15, 1959		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN FALLS CHURCH		22d. LOCATION (City, town, or county) _____ (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B DANZANSKY & SONS - 3501-14th NW		ADDRESS Springfield State Hosp. Sykesville, Md.		24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. France													

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

REPORT OF THE

COMMISSIONER OF THE

GENERAL INVESTIGATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

12406
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First GARY Middle BRIAN Last YINGLING				4. DATE OF DEATH Month November Day 22 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25 1959	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Hanover, Penna	
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Arthur Yingling				14. MOTHER'S MAIDEN NAME Marie Stonesifer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Arthur Yingling as above Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 692.1 DUE TO Cellulitis of Abdominal Wall. Conditions, if any, which gave rise to immediate cause (b) (c) 692.1 DUE TO Cellulitis of Abdominal Wall. (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 11/23/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/59		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley		22d. LOCATION (City, town, or country) (State) Pleasant Valley Md.	
23. FUNERAL DIRECTOR ADDRESS Little Funeral Home Littlestown Pa				24a. REC'D BY REGISTRAR NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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